

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

759

CERTIFICATE OF DEATH

Reg. Dist. No. 00754

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b>		c. LENGTH OF STAY IN 1b <b>9 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hyattstown Mill Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Bateman</b> Last <b>Allender</b>		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1878</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Fallston, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Lawrence Allender</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Cloman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-16-7787</b>	
17. INFORMANT <b>Mr. Bird Jacquette Allender, Item 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 422.1 DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>lying cause last.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 10, 1947, to January 27, 1961, that I last saw the deceased alive on January 26, 1961, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>James P. Kerr</b> ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>1/27/61</b> PHYSICIAN'S NAME (Type) <b>James P. Kerr</b> <b>Damascus, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>JAN. 31</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Kane</b>		24a. REC'D BY REGISTRAR <b>Feb 2 '61</b>	
ADDRESS <b>Church Hill, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Caroline S. Kline</b>	

CERTIFICATE OF DEATH

1952

Montgomery

Married

Clarkburg

State

of Maryland

Washington Hill No.

Washington Hill No.

January 27, 1952

Alfred

Edmond

Paul

Aug. 28, 1878

White

Male

USA

Clinton, Md.

Clinton

Charles W. Allen

James Lawrence W. Allen

1952-1953 Mr. and Mrs. Charles W. Allen, Jr.

No.

Danvers, Md.

Danvers, Md.

Spent 1952-1953 at  
Clinton Hill, Md.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
750  
CERTIFICATE OF DEATH  
00755

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN <b>6 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b>				4. DATE OF DEATH <b>January 24 1961</b>			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>Caucasian</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1-23-61</b>			
9. AGE (In years last birthday) <b>5</b>				10. IF UNDER 1 YEAR <b>5</b> Months <b>54</b> Days			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Kenneth F. ANDREWS</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Ann HOEHLEIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>(F) Kenneth F. Andrews, same as #2 above</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neonatal Atelectasis</b> 762-5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) <del>the hospital</del> attended the deceased from <b>Jan. 23 1961</b> to <b>Jan. 24 1961</b> that (I) <del>xxx</del> last saw the deceased alive on <b>Jan. 24 1961</b> , and that death occurred at <b>2:35 AM</b> , from the causes and on the date stated above.				22a. SIGNATURE <b>Fred W. Grello</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>1-24-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Fred W. GRELO, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>				23b. DATE THEREOF <b>1-26-60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>				23d. LOCATION (City, town, or county) (State) <b>Conway Arkansas</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b> ADDRESS <b>Bethesda, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 26 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

- 205123 2XV2

CERTIFICATE OF DEATH

170

UNKNOWN Cause of Death

Admission

8 Dec

Post-mortem (Rural)

1902 Taylor Street

U. S. Naval Hospital

January 23

Admission

Edy B.V.

24

1902-01

Commodore

USA

Medical

High and Honorable

Commander V. A. ...

(3) ... as above

Jan. 23

Jan. 24

1-24-01

U. S. Naval Hospital

Edy W. ...

...

...

...



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

761 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00756

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>5930 Kirby Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5930 Kirby Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JACK LAWRENCE ARMSTRONG, JR.</b>				4. DATE OF DEATH <b>January 27 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 21, 1947</b>	
9. AGE (In years last birthday) <b>13</b> yrs.		IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b>		IF UNDER 24 HRS. Hours <b>13</b> Min. <b>13</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Jack Lawrence Armstrong</b>			
14. MOTHER'S MAIDEN NAME <b>Audrey Bloom</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Jack Lawrence Armstrong - Father - Same #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to hanging</b> DUE TO (b) <b>936.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hanging from rope</b>			
20c. TIME OF INJURY Month, Day, Year <b>12:10 p.m. Jan. 27 1961</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>				20f. (City or town) <b>Bethesda, Montgomery, Md.</b> (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>				M.D. <b>CHARLES S. PETTY, M. D.</b>			
EXAMINER'S NAME (Type) <b>CHARLES S. PETTY, M. D.</b>				DATE SIGNED <b>1/29/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/31/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem</b>				22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>			
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>Feb 2 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>			

MEDICAL CERTIFICATION

2

15

2

TECHNICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: JACK LAWRENCE  
SEX: MALE  
DATE OF BIRTH: OCT. 21, 1917  
AGE: 33  
RACE: WHITE  
OCCUPATION: JACK LAWRENCE, JR.  
RESIDENCE: 2930 E. 10th Ave., Wash., D.C.  
DEATH: 1951  
CAUSE OF DEATH: Jack Lawrence, Jr. - Father - 2930 E. 10th Ave., Wash., D.C.  
MANNER OF DEATH: Accidental - to hangar

Signature: [Signature]  
Date: Jan. 27 - 51  
Place: [Location]  
Signature: [Signature]  
Date: [Date]  
Place: [Location]

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00757

762

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>271 Days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Darrell</b> Middle <b>James</b> Last <b>Ashley</b>			4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1934</b>		9. AGE (In years last birthday) <b>26</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Body &amp; Fender Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shop</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Arthur C. Ashley</b>			14. MOTHER'S MAIDEN NAME <b>Mollie Williams</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>YES Korean</b>		16. SOCIAL SECURITY NO. <b>246-44-9503</b>	17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Testicular choriocarcinoma</b> 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 2, 1960</b> to <b>January 28, 1961</b> that (I) (we) last saw the deceased alive on <b>January 28, 1961</b> and that death occurred at <b>9:05 AM</b> from the causes and on the date stated above.					
22a. SIGNATURE <i>Martin Nydick M.D.</i>		22b. DATE SIGNED <b>1/28/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Martin Nydick M.D.</b>	
22d. ADDRESS <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 31/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Bel Air Harford Md</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Foster</i>		25a. REC'D BY REGISTRAR DATE <b>JAN 31 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

103

TESTING OF DEATH

January 1935

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 7/59

FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00758

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1/2 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8504 16th St. NW</u>		d. STREET ADDRESS <u>1 Silver Spring md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1015 Spring St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Vivian</u>		First Middle Last <u>Anslander</u>		4. DATE OF DEATH <u>Jan 10 1961</u>		Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 25 1905</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Fleisher</u>				14. MOTHER'S MAIDEN NAME <u>Rose</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address <u>Mr. William Selen/Kor 5806 Clover Rd. Balt. 15-Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>THROMBOSIS, POSTERIOR CORONARY ARTERY</u> (c) <u>CORONARY ARTERIOSCLEROSIS, SEVERE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapse after receiving 1cc 2% Xylocaine for dental repair</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE</u> <u>ACUTE</u> <u>UNKNOWN</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-11-61</u>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-12-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shaare Tefloah</u>		22d. LOCATION (City, town, or country) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR <u>Jack Kewick</u> ADDRESS <u>3100 Eutaw Place</u>				24a. REC'D BY REGISTRAR <u>JAN 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FOR SALE  
MAY 1910

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

764  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00259

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>28 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		33	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>13412 Parkland Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Michael Balassa, SR.</u> First Middle Last				4. DATE OF DEATH <u>Jan. 28</u> 19 <u>61</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/24/94</u>	
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam engineer (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Allies Inn Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>							
13. FATHER'S NAME <u>MICHAEL BALASSA</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>170-10-6623</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Suppurative Empyema</u> 527.0 DUE TO <u>Massive Collapse lung (Surgique intervention)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Severe pneumoconiosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u> <u>3 wks.</u> <u>20-30 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 31</u> 19 <u>60</u> to <u>Jan 28</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 28</u> 19 <u>61</u> , and that death occurred at <u>7:15</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond O. West</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Mem. Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>FEB 2 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

CERTIFICATE OF DRAIN

108

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10-1-1902

10/1/02

10/1/02

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

765

## CERTIFICATE OF DEATH

00760

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> <b>b. COUNTY</b> <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>106 Woodlawn Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>(Eventide Nursing Home)</u> <u>700 Hudson Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNE L. BANGS</u>		4. DATE OF DEATH <u>January 1 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Byley Lyford</u>		14. MOTHER'S MAIDEN NAME <u>Adeliza Prescott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Louise L. Owens- 3020 Crest Avenue</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1961</u> to <u>Jan 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 1, 1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Ronald S. Fleischer</u>		22b. DATE SIGNED <u>1-1-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u>		22d. ADDRESS <u>905 SHERIDAN ST. HYATISVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>1/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tucker - Sons</u>		25a. REC'D BY REGISTRAR <u>Baltimore 17 Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		DATE <u>JAN 3 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
766 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CG761

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Silver Spring</u>		d. STREET ADDRESS <u>613 Quint Acres Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Saint Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hugh Thomas Barrett</u>				4. DATE OF DEATH Month Day Year <u>1 27 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-9</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (gas sta. OWNER)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Mr. David L. Barrett</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude E. Kiernan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-36-5697</u>		17. INFORMANT <u>Mr. Robert Barrett</u>		Address <u>SAME AS #2 (Bro)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-27-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate-of-Heaven Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Md.</u>	
23. FUNERAL DIRECTOR <u>Francis J. Collins</u>				24e. REC'D BY REGISTRAR Address <u>3821-14th St NW, Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

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JAN 30 '61

(2000)

2002-11-11



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

60762

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	c. LENGTH OF STAY IN 1b <b>23 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1543 N. Falkland Lane</b>		d. STREET ADDRESS <b>1543 N. Falkland Lane</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>LOCKHART</b> Last <b>BAYLOR</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>16</b> Year <b>61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/23/84</b>
9. AGE (In years lost birthday) <b>76</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>16</b> Hours <b>19</b> Min. <b>61</b>	11. IF UNDER 24 HRS. Months <b>2</b> Days <b>16</b> Hours <b>19</b> Min. <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			

13. FATHER'S NAME <b>MONROE ROBINSON</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE LOCKHART</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Charles McIntosh Baylor, 1543 N. Falkland La.</b>		Address <b>Silver Spring, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 hrs.</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>March 10, 1943</b> , to <b>January 16, 1961</b> , that I last saw the deceased alive on <b>January 16, 1961</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>W. B. WARDROP</b>	DATE SIGNED <b>8:30 P. M. Pershing Drive, Silver Spring, Md. 1/17/61</b>
PHYSICIAN'S NAME (Type) <b>W. B. WARDROP</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/19/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. WARDROP, INC.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 25 '61</b>	
ADDRESS <b>Silver Spring, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>John E. Hume</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

203



769

## CERTIFICATE OF DEATH

Reg. Dist. No.

00763

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5047 Bradley Blvd</u>			
3. NAME OF DECEASED (Type or print) First <u>Sharon</u> Middle <u>Denise</u> Last <u>Bennett</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 3 1961</u>		9. AGE (In years lost birthday) yrs. <u>1.7</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>17</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Sub. Hosp. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Russell Norman Bennett</u>				14. MOTHER'S M maiden name <u>Anna Marie Devlin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mather</u> Address <u>5047 Bradley Blvd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATBLE CTASIS</u> <u>762.5</u> DUE TO <u>PRBMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 3</u> , 19 <u>61</u> , to <u>JAN 4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>JAN 4</u> , 19 <u>61</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>1/9/61</u>							
ACTUAL SIGNATURE <u>Law. Peilman</u> M.D.				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-5-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____				24a. REC'D BY REGISTRAR DATE <u>JAN 16 61</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll S. Thomas</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074182 XV 2

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00764

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>134 Madison Street, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Raymond</b> Last <b>BIVENS</b>			4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>1-15-61</b>		9. AGE (In years lost birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Ted E. BIVENS</b>			
14. MOTHER'S MAIDEN NAME <b>Joyce A. FIGURSKI</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(F) Ted E. Bivens, same as #2 above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyland Membran Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>19 hr.</b> <b>27 1/2 hr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)			
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>Birth 1-15-61</b> to <b>Jan. 16, 1961</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>Jan. 16, 1961</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Lawrence G. Thorne</b> M.D.		22b. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		22c. PHYSICIAN'S NAME (Type) <b>Lawrence G. THORNE, LT, MC, USN</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>1-17-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Benet Chapel Cemetery</b>			
23d. LOCATION (City, town, or county) <b>South Shore</b>		23e. LOCATION (City, town, or county) <b>Kentucky</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b> ADDRESS <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH

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San Francisco

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U. S. Naval Hospital

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 771 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00765

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>09</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>510 N. Horners Lane</u>				d. STREET ADDRESS <u>510 N. Horners Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>HARRY M. BOLTON</u>				4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11/16/1900</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>US</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>James Bolton</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Frances L. Emswiler-Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/14/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Potomac</u>	
				22d. LOCATION (City, town, or county) <u>Potomac, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lyson Wheeler Funeral Home</u> <u>1331 E. Montgomery Ave., Rockville Md</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
				DATE <u>JAN 16 '61</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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772  
MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00766

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc.</u>				d. STREET ADDRESS <u>4751 Berkeley Terrace NW</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wallace</u> Last <u>Brackett</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 2, 1865</u>	
9. AGE (In years lost birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>95</u> Days <u>95</u> Hours <u>95</u> Min. <u>95</u>		IF UNDER 24 HRS. Months <u>95</u> Days <u>95</u> Hours <u>95</u> Min. <u>95</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M.D., retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wis.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Brackett</u>				14. MOTHER'S MAIDEN NAME <u>Luema Hamilton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>James R. Brackett 4751 Berkeley Terrace NW, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia</u> DUE TO <u>Infection + Cocci</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 mo.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>9-10, 1959</u> to <u>Jan 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 1, 1961</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Roy B. Parsons</u> M.D.				22b. DATE SIGNED <u>Jan. 6, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROY B. PARSONS</u>				22d. ADDRESS <u>Burtonsville Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN. 9 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Baker</u> ADDRESS <u>Saytownville Md</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

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1911

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

773

## CERTIFICATE OF DEATH

60767

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY in 1b <i>8 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Wash. Sanitarium &amp; Hosp.</i>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <i>Wash. D.C.</i> b. COUNTY <i>✓</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>477X-3</i> d. STREET ADDRESS <i>3210 Klinge Rd. NW</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <i>FRANCES Amelia Brining</i> First Middle Last		<b>4. DATE OF DEATH</b> <i>1-2-61</i> Month Day Year			
<b>5. SEX</b> <i>Female</i> <b>6. COLOR OR RACE</b> <i>White</i> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>9-28-1870</i> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>9. AGE</b> (In years last birthday) <i>80</i> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>ASWX</i> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>MARYLAND</i> <b>12. CITIZEN OF WHAT COUNTRY? <i>AMERICA</i> </b>				
<b>13. FATHER'S NAME</b> <i>Hyman</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Weckler</i>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>no</i> <b>16. SOCIAL SECURITY NO.</b> <i>-</i> <b>17. INFORMANT</b> <i>Hosp record.</i> Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i> 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>C-V-accident</i> (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i> <i>10 days.</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Diabetes Mellitus</i>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <i>19</i>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <i>1949</i> to <i>Jan 2, 1961</i> , that (I) (we) last saw the deceased alive on <i>Jan 2, 1961</i> , and that death occurred <i>6:25 PM</i> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <i>Robert A. Hare</i> M.D.		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>	<b>22b. DATE SIGNED</b> <i>1/3/61</i>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <i>Robert A. Hare MD</i>		<b>22d. ADDRESS</b> <i>7600 Carroll Ave. Tak. PK. Md</i>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>	<b>23b. DATE THEREOF</b> <i>1/4/61</i>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Boonsboro Cemetery</i>	<b>23d. LOCATION</b> (City, town or county) <i>Boonsboro, Maryland</i> (State)		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Robert A. Humphrey</i>		<b>ADDRESS</b> <i>Bethesda, Maryland</i>		<b>25a. REC'D BY REGISTRAR</b> <i>DATE JAN 5 '61</i>	
		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN lb <u>10 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12304 Dewey Road</u>	
3. NAME OF DECEASED (Type or print) <u>Eunice Edessa Broderick</u> First <u>Edessa</u> Middle <u>Broderick</u> Last <u>Broderick</u>		4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-92</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>30</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Harry Lowell</u>	
14. MOTHER'S MAIDEN NAME <u>Mabel Hackett</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>439-24-9479</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial infarction</u> (a), stating the underlying cause last. (c) <u>A.S.C.U.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1960</u> to <u>Jan 30, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 30, 1961</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles M. Weber M.D.</u>		22b. ADDRESS <u>10,620 Ga. Ave., Silver Spring, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES M. WEBER</u>		22d. ADDRESS <u>10,620 Ga. Ave., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/3/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u>		25. REC'D BY REGISTRAR <u>DATE FEB 7 '61</u>	
25a. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>		25b. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

60769

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. LENGTH OF STAY IN 1b <b>54</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4102 Woodbine Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Virginia</b> Last <b>Brooke</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>16</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 3, 1916</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>13</b> Hours <b>13</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Francis C. Brooke</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Francis C. Brooke, Jr.-Brother-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> DUE TO <b>581.9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe rhinorrhea (nose)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Low blood clotting power -</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>3 mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 16, 1954</b> to <b>Jan 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 13, 1961</b> , and that death occurred at <b>5:40</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Gilbert B. Rude</b>				22b. DATE SIGNED <b>1/16/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Gilbert B Rude</b>				22d. ADDRESS <b>3900 Military rd. N.W.D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/18/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Warrenton Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Warrenton, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>			
25b. REGISTRAR'S SIGNATURE <b>Jan 18 '61</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

# CERTIFICATE OF DEATH

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Mary A. Wilson

Francis C. Brown

Francis C. Brown, Jr. - Brother - 10

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Warren G. Gentry

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Bohanna, Maryland

Bohanna, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Springs, Md</u>				c. LENGTH OF STAY IN 1b <u>30 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>E.</u> Last <u>BROOKS</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/4/1887</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas H. Brooks</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Frances Hall</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Rosa A. Brooks (Same as above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion in thrombosis + myocardial infarction</u> DUE TO (b) <u>EVD + Sen. Art. Sclerosis</u> DUE TO (c) <u>Chronic passive cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u> <u>3 yrs</u> <u>5 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4 p.m.</u> <u>1960</u> to <u>31 Jan</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>31 Jan</u> <u>1961</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John Bosley Ziegler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3 Feb 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>				22d. ADDRESS <u>OLNEY, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Inman</u>				ADDRESS <u>Rockville, Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

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CERTIFICATE OF DEATH

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Blank certificate form with horizontal lines for text entry.



**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be retained by the hospital or attending physician.

Page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

66770

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton</b>		<b>03X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>Meadowbrook</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Allen</b> Middle <b>Ross</b> Last <b>BROUGHAM</b>				4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-1-13</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herbert BROUGHAM</b>				14. MOTHER'S MAIDEN NAME <b>Nettie I. HILL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWII-Korean 577-09-1309</b>		17. INFORMANT <b>(W) Mrs. Jane Brougham, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis, liver, Laennec's</b> DUE TO 581.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (u) (this hospital) attended the deceased from <b>Jan. 17 1961</b> to <b>Jan. 20 1961</b> that (x) (we) last saw the deceased alive on <b>Jan. 20 1961</b> and that death occurred at <b>7:35AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>M. William Voss</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-21-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. William Voss, LCDR, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE/THEREOF <b>1-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>At sea</b>		23d. LOCATION (City, town, or county) (State) <b>Norfolk Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Pumphrey Funeral Home, Silver Spring, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

U. S. Navy Hospital, Bethesda, Md.

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U. S. Navy Hospital, Bethesda, Md.

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U. S. Navy Hospital, Bethesda, Md.

Yos Will-Kenn 21-03-1307 (W) Mrs. John Brown, age 45 above

Robert M. Brown

Robert I. Hill

Belmont

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BROOKMAN

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U. S. Navy Hospital

Washington

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Belmont

Thompson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No.

60771

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>K.</b> Last <b>Burch</b>		4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/8/1871</b>
9. AGE (In years last birthday) yrs. <b>89</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C. Kraak</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Mueller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Hospital Records--</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, acute</b> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis, advanced</b> DUE TO (c) <b>Arteriosclerosis, generalised</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b> <b>5 yrs +</b> <b>10 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma, left breast</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> , to <b>1-25-61</b> , that I last saw the deceased alive on <b>1-16-61</b> , 19 <b>61</b> , and that death occurred at <b>8:25 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stewart Clapp</b>		DATE SIGNED <b>1-25-61</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp M.D.</b>		ADDRESS (Street, city or town, state) <b>4740 Chevy Chase Dr. Washington 15 Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/28/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>JAN 26 '61</b>	
ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraak</b>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10772

1. PLACE OF DEATH a. COUNTY <i>Montg</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
c. LENGTH OF STAY IN 1b <i>1 wk</i>				d. STREET ADDRESS <i>8800 Plymouth Street</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>5502 Glenwood Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Elsie</i>		First Middle Last <i>M Burney</i>		4. DATE OF DEATH <i>Jan 17 1961</i>		Month Day Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 13, 1893</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>		11. BIRTHPLACE (State or foreign country) <i>Maine</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John M. McLaughlin</i>				14. MOTHER'S MAIDEN NAME <i>Libby (Unknown)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>005-32-2387A</i>			
				17. INFORMANT <i>Mrs. Barbour-daughter</i> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>420.1</i> IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>Found dead on floor</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Blaschke</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Blaschke</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <i>1-17-61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>1/18/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Bab View Cemetery</i>		22d. LOCATION (City, town, or country) (State) <i>S. Portland, Maine</i>	
23. FUNERAL DIRECTOR <i>Robert A. Pumphrey Bethesda, Maryland</i>				24a. REC'D BY REGISTRAR <i>Jan 19 '61</i>			
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kinn</i>			

MEDICAL CERTIFICATION

FOR DATE  
HEARD BY

U.S. MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
DEPARTMENT OF HEALTH  
MONTGOMERY, ALABAMA

Montgomery

Harvard

Silver Spring

8320 Plymouth Street

Female White X April 12, 1993 57

Housewife ----- Name

John A. Melanin (liber) (unknown)

No 002-32-2227 Mrs. Harbour-daughter

Robert A. Humphrey, Detective, Montgomery, Alabama  
Burial certificate 1/18/91 and view cemetery  
S. Fortland, Name



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M  
X  
1  
2  
1

780

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

60773

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4616 Chevy Chase Blvd</b>				d. STREET ADDRESS <b>4616 Chevy Chase Blvd., 1</b>			
3. NAME OF DECEASED (Type or print) First <b>Oliver</b> Middle <b>F</b> Last <b>Busby</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 15, 1879</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>John Busby</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Katie B. Busby-daughter-same 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1/11/61</b> 19 <b>61</b> , to <b>1/15</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>1/14/61</b> 19 <b>61</b> , and that death occurred at <b>8:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr J Kenrick</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr JOSEPH KENRICK</b>				22d. ADDRESS <b>6450 Wisconsin Ave, Bethesda, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 19 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

CENTRAL CASE OF DEATH

1908

January

February

Cherry Chase

Cherry Chase

Cherry Chase

Cherry Chase

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

Cherry

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

60774

781

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson---Rural</b>				c. LENGTH OF STAY IN 1b <b>93 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Spates</b> Last <b>Butler</b>				4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 11-1868</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm--Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Charles M. Butler</b>				14. MOTHER'S MAIDEN NAME <b>Frances Spates</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-36-7274</b>		INFORMANT Address <b>George Butler, Dickerson-R.F.D. Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> DUE TO (c) <b>8 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchio pneumonia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 19</b> , 19 <b>61</b> , to <b>Jan 20</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan 19</b> , 19 <b>61</b> , and that death occurred at <b>6:45 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Vernon E. Martens</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Vernon E. Martens</b> <b>Sermanston</b> <b>md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/24/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>				ADDRESS <b>Barnesville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 24 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Barthel 12/2/51 Monocacy  
Hannockville, Md

Boalville, Maryland

No 217-30-7374 George Butler, Dickerson-R.F.D. Md

Charles M. Butler Frances Butler

Farm--Owner

Maryland

U.S.

Male White

Jan. 11-1864

82

Charles Butler

January 20

51

Dickerson--Barthel

93 yrs

Dickerson-Barthel

Maryland

Montgomery

Charles S. Evans

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

302

NO. 1000

DECEASED

AGE 1 YR

SEX

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



## CERTIFICATE OF DEATH

Reg. Dist. No.

06776

783

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17424 CARROLL AVE.</u>				d. STREET ADDRESS <u>17424 CARROLL AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW D.H. CAMPBELL</u>				4. DATE OF DEATH Month Day Year <u>JAN 22 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 23 1907</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TORONTO CANADA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>				13. FATHER'S NAME <u>GEORGE CAMPBELL</u>			
14. MOTHER'S MAIDEN NAME <u>CATHLEEN CAMPBELL</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> If yes, give war or dates of service			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>MRS MARJORY N. CAMPBELL (Room #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> 420.1 DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASSOCIATED MALIGNANT BRAIN TUMOR</u> DUE TO (c) <u>ASSOCIATED MALIGNANT BRAIN TUMOR</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>DEC 1, 1960</u> to <u>JAN 22, 1961</u> , that I last saw the deceased alive on <u>JAN. 12, 1961</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur P. Hustead</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 1150 CONNECTICUT AVE 1/22/61</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR P. HUSTEAD, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>JAN-26/1961</u>		<u>Prospect Cemetery</u>		<u>Toronto Canada</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Arthur Walton, 254 Canal Dr NW</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

784

## CERTIFICATE OF DEATH

0777

<b>1. PLACE OF DEATH</b> a. COUNTY <u>M. MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN lb <u>10 mins.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 BETHESDA</u> d. STREET ADDRESS <u>1 4530 AVONDALE ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>CLARA</u> <u>CERNIGLIA</u>		<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>7</u> Year <u>19 61</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>April 27 1884</u>		<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (Country State, or foreign country) <u>Italy</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u> <u>40 yrs</u>		
<b>13. FATHER'S NAME</b> <u>Unknown</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Fronte</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Camilla Cerniglia (Daughter Same as Above)</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 cardiovascular collapse</u> (b) <u>coronary thrombosis</u> (c) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>5+ years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>acute congestive heart failure</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>March 19 56</u> to <u>Jan 7 19 61</u> that (I) (we) last saw the deceased alive on <u>Jan 7 19 61</u> , and that death occurred at <u>8 PM</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Wilfred R. Ehrmantraut</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>1/7/61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Wilfred R. Ehrmantraut M.D.</u>		<b>22d. ADDRESS</b> <u>4890 Battery Lane, Bethesda</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Buried</u>	<b>23b. DATE THEREOF</b> <u>1/10/61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral Cms</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, MD</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Cheryl Chase Funeral Home</u>		<b>ADDRESS</b> <u>510 N. Washington St.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 11 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
785  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00778

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>103 Longfellow St., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Edwin</b> Last <b>CLARK</b>				4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1961</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-7-86</b>		9. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>				11. BIRTHPLACE (State or foreign country) <b>Iowa</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edwin James CLARK</b>						14. MOTHER'S MAIDEN NAME <b>Bertha Inez BURKE</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I 579 09 9112</b>				17. INFORMANT <b>Mr. Philip Curtis, 708 Silver Spring, Mve. Silver Spring, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 min.</b> <b>16 years</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1-22-</b> <b>1961</b> to <b>1-28-</b> <b>1961</b> that (I) (we) last saw the deceased alive on <b>1-28-</b> <b>1961</b> and that death occurred at <b>1:13AM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>William P. Baker</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-28-61</b>							
22c. PHYSICIAN'S NAME (Type) <b>W.P. Baker, LT, MC, USN</b>						22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2-1-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				23d. LOCATION (City, town, or county) <b>Arlington, Virginia</b> (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>LEE FUNERAL HOME, 4th &amp; Mass. Ave. N.W. Washington, D.C.</b>						25a. REC'D BY REGISTRAR DATE <b>JAN 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

Robert:

slat

10-7-00

• • •



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00779

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1915 Valley Stream Drive</b>				d. STREET ADDRESS <b>1915 Valley Stream Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>D.</b> Last <b>CLARK Jr.</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>26,</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 30, 1918</b>		
9. AGE (in years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>26</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William D. Clark</b>				14. MOTHER'S MAIDEN NAME <b>Carrie England</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>W. W. II 217-03-2518</b>		17. INFORMANT Address <b>Mrs. Iva Clark-Wife-Same Item #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>Jan. 26, 1961</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 30 '61</b>		
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00780

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>7 mo</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2609 Blue Ridge Ave</u>				d. STREET ADDRESS <u>1 2609 Blue Ridge Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph E Coker</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-8-1903</u>	
9. AGE (in years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coast Guard of Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Coker</u>				14. MOTHER'S MAIDEN NAME <u>Marie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>218-30-28</u>			
17. INFORMANT <u>Marie Coker (wife)</u>				Address <u>Stim 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>1-11-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-13-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall</u>		22d. LOCATION (City, town, or country) (State) <u>71 Myer Va</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>				ADDRESS <u>1400 Chapin St N.</u>		24a. REC'D BY REGISTRAR <u>JAN 16 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruas</u>			

MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH



OFFICE OF THE  
COMMISSIONER OF HEALTH  
100 NORTH EIGHTH STREET  
BALTIMORE, MARYLAND 21201  
TELEPHONE 572-1000

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1954

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Death: *10/15/54*

5. Place of Death: *Home*

6. Cause of Death: *Myocardial Infarction*

7. Manner of Death: *Natural*

8. Signature of Medical Examiner: *[Signature]*

9. Date of Signature: *10/16/54*

10. Signature of Coroner: *[Signature]*

11. Date of Signature: *10/16/54*

728

VS A15 (4)  
ISM 9/58

**DEPUTY FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL CERTIFICATION

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		MARYLAND		b. COUNTY		PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		AVENUE					
WASHINGTON SANITARIUM & HOSPITAL				6602 24th. ST. N.W.							
3. NAME OF DECEASED (Type or print)		Also (FRANCIS J. COLLELI Middle)		Last		4. DATE OF DEATH		Month		Day	
FRANK COLLELI						JAN		11		1961	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11-17-94		66 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
SERVICE MANAGER		AUTOMOBILE		WASHINGTON, D.C.		U. S. A.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
RAFFAELA COLLELI				FORTUNATA GRECO							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				INFORMANT			
Yes				WORLD WAR I 218-20-1847				CATHERINE V. COLLELI			
								SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease 1 yr. (c)										INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 5/13, 1957, to JAN 11, 1961, that I last saw the deceased alive on JAN 10, 1961, and that death occurred at 7:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 3503 Penny ST DATE SIGNED 1/11/61									
ACTUAL SIGNATURE Norman Donat Comeru		PHYSICIAN'S NAME (Type) Norman Donat Comeru MT RAINIER MD									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)			
BURIAL		1-14-61		MT. OLIVET CEMETERY		WASHINGTON		D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS WASH. D.C.		24a. REC'D BY REGISTRAR DATE JAN 16 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

Mont. Co. Deputy Medical Examiner notified.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
789 CERTIFICATE OF DEATH 00782									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>					c. LENGTH OF STAY IN 1b <b>116 days</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Florence Virginia COLLINS</b>					4. DATE OF DEATH Month Day Year <b>January 7 19 61</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-22-81</b>		9. AGE (In years last birthday) <b>79</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Mic higan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John J. TONKIN</b>					14. MOTHER'S MAIDEN NAME <b>Virginia WEBSTER</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>- - -</b>		17. INFORMANT <b>(H) Robt. H. Collins, same as #2 above</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Arteriosclerotic Heart Disease</b> DUE TO <b>34 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture Intertrochanteric left hip</b> DUE TO <b>4 mos</b> (c) <b>with post-operative Staplylococcal Infection</b> <b>3.9 mos</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (H) (this hospital) attended the deceased from <b>Sept. 13 19 60</b> to <b>Jan. 7 19 61</b> that (H) (we) last saw the deceased alive on <b>Jan. 7 19 61</b> , and that death occurred at <b>1:15 PM</b> from the causes and on the date stated above. 22a. SIGNATURE <b>L. V. WILLETT, LT, MC, USN</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>1-7-61</b> 22c. PHYSICIAN'S NAME (Type) <b>U. S. Naval Hospital, Bethesda, Md.</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1-11-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b> 23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Shavel</b> ADDRESS <b>Va.</b> 25a. REC'D BY REGISTRAR <b>Ives Funeral Home, 2847 Wilson Blvd., Arlington, DATE JAN 10 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>									

RECEIVED: CO. DATED JANUARY 1941

with part of the left hip  
fracture, fracture of the left hip  
3445

No. 1 - - - - - (R) Robert H. Collins, same as above

John J. FOWLER

Virginia WEBSTER

Honolulu

Miss High

USA

University

1-22-41

17

Virginia

COLLINS

January 7

1941 H. FOWLER

U. S. Naval Hospital

116 days

Virginia

116 days (1941)

Virginia

Virginia

116 days

1 **M** 051  
790  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH** 00783

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>64 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Wilfred</b> Middle <b>James</b> Last <b>COLLINS</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-7-28</b>	9. AGE (In years last birthday) <b>32</b> yrs.	IF UNDER 1 YEAR Months <b>32</b> Days <b>3</b> Hours <b>3</b> Min.	IF UNDER 24 HRS. Months <b>32</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William C. COLLINS</b>				14. MOTHER'S MAIDEN NAME <b>Levina SELLERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1946-1960</b>		17. INFORMANT <b>1916 Kingston St., Norfolk, Va.</b> <b>(W) Mrs. Inez Collins, c/o Holzmilller</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basophilic Cell Sarcoma</b> 1977.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1977.9</b> DUE TO (c) <b>1977.9</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>10:15AM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 29</b> <b>1960</b> to <b>Jan. 31</b> <b>1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 31</b> <b>1961</b> , and that death occurred at <b>10:15AM</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Paul P. Linaweaver, LT, MC, USN</b>				22b. DATE SIGNED <b>1-31-61</b>		22c. PHYSICIAN'S NAME (Type) <b>P. G. LINAWEAVER, LT, MC, USN</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>				22e. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 2-2-61</b>		23b. DATE THEREOF <b>2-2-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Norfolk Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>				25a. REC'D BY REGISTRAR <b>FEB 2 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>	
24. ADDRESS <b>W.W. Chambers Co., 1400 Chapin St. NW, WashDC</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>			

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

791

## CERTIFICATE OF DEATH

Reg. Dist. No.

00784

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>26 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL HALL SANITORIUM</b>		d. STREET ADDRESS <b>624 EVARTS STREET, N.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>ELIZABETH</b> Last <b>CORBLEY</b>		4. DATE OF DEATH Month <b>JAN</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-71</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min.	11. IF UNDER 24 HRS. Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNA.</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL J. KELLY</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET HACKETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>no</b>	
17. INFORMANT <b>JOSEPH T. CORBLEY SR.</b>		18. ADDRESS <b>3380 STUY VESTANT N.W. WASH. D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 8</b> , 19 <b>60</b> , to <b>JAN 3</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1-3</b> , 19 <b>61</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5206 NORWICH DR.</b> DATE SIGNED <b>CHEVY CHASE, MD</b> ACTUAL SIGNATURE <b>Francis J. Collins</b> M.D. <b>5206 NORWICH DR.</b> PHYSICIAN'S NAME (Type) <b>FRANCIS J. COLLINS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-7-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. OLIVET CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Collins</b>		24a. REC'D BY REGISTRAR <b>Francis J. Collins</b>	
24b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>		DATE <b>JAN 6 '61</b>	

CERTIFICATE OF DEATH

101

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
793  
CERTIFICATE OF DEATH

00786

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Montgomery</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>		c. LENGTH OF STAY IN 1b <i>6 mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bethelwood Rest Home, Gaithersburg</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Gaithersburg</i>	
3. NAME OF DECEASED (Type or print) <i>Nellie</i> First <i>Genetta</i> Middle <i>Crawford</i> Last		4. DATE OF DEATH <i>January - 26 - 1961</i> Month <i>January</i> Day <i>26</i> Year <i>1961</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March - 7 - 1870</i>
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR <i>10</i> Months <i>19</i> Days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-keeping</i>		12. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
13. FATHER'S NAME <i>S. B. Croon</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Dorothy Croon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Ruth H. Brown, R1, Gaithersburg, Md</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Stomach</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <i>Cancer of left breast</i> DUE TO (c) <i>7 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7 - 19 - 1960</i> to <i>Jan - 26 - 1961</i> , that (I) (we) last saw the deceased alive on <i>Jan - 12 - 1961</i> , and that death occurred at <i>22</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>William C. Miller</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		22d. ADDRESS <i>7-Brookside, Gaithersburg, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-29-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Fairview</i>		23d. LOCATION (City, town, or county) (State) <i>Germanstown Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur E. Kraus</i> ADDRESS <i>Gaithersburg Md.</i>		25. REC'D BY REGISTRAR <i>Arthur E. Kraus</i> DATE <i>JAN 30 '61</i>	

*[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]*

794  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. LENGTH OF STAY IN 1b <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL HALL SAN.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>Phillips</u> Last <u>CRISWELL</u>				4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1874</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dreyer, William</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beckmann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		INFORMANT <u>E.B. Phillips 29 Wildwood Road Scarsdale, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last: (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>MARCH 15, 1959</u> , to <u>1-10, 1961</u> , that I last saw the deceased alive on <u>1-10, 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry M. Lowden</u>		M.D. <u>5206 Venable Dr.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Henry M. Lowden</u>		<u>Cherry Chase, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/13/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 16 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL BUREAU OF DEATH

1984

Form with multiple sections and fields, mostly illegible due to fading. Visible text includes "CENTRAL BUREAU OF DEATH" and "1984".



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3795  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00788

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>Since 1928</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,401 COLESVILLE ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BEATRICE</b> Middle <b>W.</b> Last <b>CROCKER</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>15</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/17/02</b>	
9. AGE (In years lost birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kensington Junior High School</b>			
11. BIRTHPLACE (State or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Benjamin Woodford</b>				14. MOTHER'S MAIDEN NAME <b>Lucretia B. Kinsman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>226-42-6570</b>			
17. INFORMANT <b>Mr. Arthur W. Crocker, 10,401 Colesville Rd. Silver Spring, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma originating in the breast - severe anemia + congestive failure</b> DUE TO (b) <b>failure</b> DUE TO (c) <b>failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 mos.</b> INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1, 1957</b> , to <b>15 Jan. 1961</b> , that (I) (we) last saw the deceased alive on <b>15 Jan. 1961</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Ernest E. Harmon</b>				22b. DATE SIGNED <b>1/15/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>ERNEST E. HARMON</b>				22d. ADDRESS <b>9301 Colesville Road, Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1/18/61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Lewinsville Presbyterian Church</b>				23d. LOCATION (City, town, or county) (State) <b>Lewinsville, Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pomarey, Inc.</b>				25a. REC'D BY REGISTRAR <b>DATE JAN 25 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinsman</b>							

CERTIFICATE OF DEATH

1932

1932

DECEASED

DATE

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

CAUSE

PLACE

DATE

SIGNATURE

DATE

1932

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
e. STREET ADDRESS <u>12810 Turkey Branch</u>		f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY Girl Dalessandro</u>		4. DATE OF DEATH <u>January 24 1961</u>	
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/61</u>
9. AGE (In years last birthday) <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Mr. Ronald Dalessandro</u>		14. MOTHER'S MAIDEN NAME <u>THELSEA DORENE LASHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MOTHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Depression Respiratory Center</u> <u>752X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hydrocephally, congenital</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/23/61</u> to <u>1/24/61</u> that (I) <u>last</u> saw the deceased alive on <u>1/24/61</u> 19 <u>61</u> , and that death occurred on <u>1/24/61</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard M. Auld</u>		22b. DATE SIGNED <u>1/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD M. AULD</u>		22d. ADDRESS <u>809 Viers Mill Rd., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/26/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Gaska</u>		25a. REC'D BY REGISTRAR <u>JAN 27 1961</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	

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*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into a table with multiple columns and rows.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

797

Sec. 23 Film G278 1-10-61 et

00790

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1363 F Street, N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lealer DANCY</b>		4. DATE OF DEATH Month Day Year <b>January 2 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-03</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jolly DRAKE</b>		14. MOTHER'S MAIDEN NAME <b>Cindy LYONS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(D) Mrs. Lossie B. Gilbert, same as #2</b>	
17. INFORMANT <b>(D) Mrs. Lossie B. Gilbert, same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolization</b> DUE TO (b) <b>Thrombophlebitis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>464X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 24 1960</b> to <b>Jan. 2 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 2 1961</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William P. Baker</b>		22b. DATE SIGNED <b>1-3-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>William P. BAKER, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial - Tran. C. B. Kelly</b>		23b. DATE THEREOF <b>Jan. 2 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>National Harmony Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Spangler Funeral Home, 524 8th St. NE, WashDC</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 6 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>	

1937

STATE OF TEXAS

1937

Department of Commerce

Maritime

Washington

Days

Receivable (Rental)

1937 P. 1937, K.M.

U. S. Naval Hospital

RECEIVED

January 2

57

6-2-37

Receivable

Receivable

RECEIVED

North Carolina

Receivable

CLARK TOWNS

CLARK TOWNS

(P) Mrs. James H. Gilbert, born in 19

NO

*James H. Gilbert*  
*1937*

Dec. 24

Jan. 2

1-3-37

U. S. Naval Hospital, Baltimore, Md.

U. S. Naval Hospital, Baltimore, Md.

Springer Control Room, 2nd St. N.E., Wash. D.C.



1  
FOR STATE  
HEALTH DEPT.

is necessary, if any, to the funeral director, Page 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00791											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>35 yrs</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11608 Rockville Pike</u>				d. STREET ADDRESS <u>11608 Rockville Pike</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George T. Darme</u>		First Middle Last		4. DATE OF DEATH <u>Jan 8 1961</u>		Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-8-1898</u>		9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>				11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. Darme</u>				14. MOTHER'S MAIDEN NAME <u>Maine Cronson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Bessie Darme - Sister</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-8-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>					
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

60792

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				c. LENGTH OF STAY IN 1b <i>6 DAYS</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanitarium</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Frank A DeFries</i>				4. DATE OF DEATH Month <i>1</i> Day <i>1</i> Year <i>1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8 Mar. 1879</i>	9. AGE (In years last birthday) <i>81</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>		11. BIRTHPLACE (State or foreign country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>August H. DeFries</i>				14. MOTHER'S MAIDEN NAME <i>Mary Bish</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Daughter</i>		Address <i>Same as item #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1) Renal failure (Nephrosclerosis)</i> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>2) Congestive cardiac failure</i> DUE TO (c) <i>1</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i> <i>7 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prostatectomy, 1954 (hyperthrophy, benign)</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 31, 1960</i> to <i>Jan. 1, 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec. 31, 1960</i> , and that death occurred at <i>3:55 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Philip H. Varner</i>				22b. ADDRESS <i>10,620 Ha. Ave., Wheaton, Md.</i>		22c. PHYSICIAN'S NAME (Type) <i>PHILIP H. VARNER</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Jan. 3, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	
23d. LOCATION (City, town, or county) <i>Montgomery County, Md.</i>				23e. REC'D BY REGISTRAR <i>Jan 3 '61</i>		23f. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHERY</i>				ADDRESS <i>Bethesda, Md.</i>			

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CERTIFICATE OF DEATH



Registration

1901

17001 North St.

St. Albans

St. Albans

St. Albans

St. Albans

1

Dec. 1, 1901

ROBERT A. PUTNEY

St. Albans, Vt.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

800

## CERTIFICATE OF DEATH

00793

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakema Park</u> c. LENGTH OF STAY IN 1b <u>2000 6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitorium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>804 Philadelphia</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Victor</u>		First <u>Victor</u> Middle <u>none</u> Last <u>Deisath, JR.</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>25</u> Year <u>1961</u>									
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-13-11</u>		<b>9. AGE</b> (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineering (Electric Engineering Aide)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>PA</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>PA</u>									
<b>13. FATHER'S NAME</b> <u>Victor Deisath</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Myer</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>none</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>171-01-6401</u>		<b>17. INFORMANT</b> <u>Pls. Ernest - Washington San. &amp; Hosp.</u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <table style="width: 100%;"> <tr> <td style="width: 30%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>330 X</u> </td> <td style="width: 40%;"> <b>DUE TO</b>  <u>Circulatory collapse</u> </td> <td style="width: 30%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>6 hours</u> </td> </tr> <tr> <td rowspan="2">                     Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                 </td> <td> <b>(b)</b>  <u>Intracerebral haemorrhage</u> </td> <td> <u>3 weeks</u> </td> </tr> <tr> <td> <b>(c)</b>  <u>Ruptured intracranial aneurysm</u> </td> <td> <u>10 weeks</u> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>330 X</u>	<b>DUE TO</b> <u>Circulatory collapse</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 hours</u>	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	<b>(b)</b> <u>Intracerebral haemorrhage</u>	<u>3 weeks</u>	<b>(c)</b> <u>Ruptured intracranial aneurysm</u>	<u>10 weeks</u>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>330 X</u>	<b>DUE TO</b> <u>Circulatory collapse</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 hours</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	<b>(b)</b> <u>Intracerebral haemorrhage</u>	<u>3 weeks</u>											
	<b>(c)</b> <u>Ruptured intracranial aneurysm</u>	<u>10 weeks</u>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)									
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Nov 27, 1960</u> to <u>JAN 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>JAN 25 1961</u> , and that death occurred at <u>1030A</u> M, from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>John T. Lord</u>		<b>22b. DATE SIGNED</b> <u>1/27/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>John T. Lord</u>									
<b>22d. ADDRESS</b> <u>1015 Spring St. Silver Spring, Md</u>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>1/28/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CONYNGHAM CEMETERY</u>									
<b>23d. LOCATION</b> (City, town or county) (State) <u>CONYNGHAM, LUZERNE COUNTY, PA.</u>													
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond E. Pumphrey, INC</u>		<b>ADDRESS</b> <u>SILVER SPRING, MD.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>JAN 31 '61</u>									
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
801 CERTIFICATE OF DEATH 60794

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>MONTGOMERY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ROCKVILLE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pensington Gardens Sanitorium</i>		d. STREET ADDRESS <i>12,113 HUNTERS LANE</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Eunice</i> Middle <i>Jenkins</i> Last <i>Devol</i>		4. DATE OF DEATH Month <i>1</i> - Day <i>19</i> - Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>13 March 1901</i>
9. AGE (In years last birthday) <i>59</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>19</i> Hours <i>19</i> Min.	11. IF UNDER 24 HRS. Months <i>1</i> Days <i>19</i> Hours <i>19</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Mother</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>College Fraternity</i>	
11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Arthur Jenkins</i>		14. MOTHER'S MAIDEN NAME <i>Frances Campbell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>yes</i>	
17. INFORMANT Address <i>Mr. Edward F. Devol, Jr., 12,113 Hunters Lane Rockville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of Uterus</i> <i>174-X</i> DUE TO <i>with local metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>10 mos</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4/3/1960</i> to <i>1/13/1961</i> , that (I) <i>last</i> saw the deceased alive on <i>1/13/1961</i> , and that death occurred at <i>11:45</i> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Russell B. Arnold</i> M.D.		22b. DATE SIGNED <i>1/19/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Russell B. Arnold M.D.</i>		22d. ADDRESS <i>8801 Colesville Road, Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. &amp; BURIAL</i>		23b. DATE THEREOF <i>1/21/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>FAIRVIEW CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>New Albany, Indiana</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Pumphrey, INC.</i> ADDRESS <i>SILVER SPRING, MD.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 25 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal document, possibly a charter or deed, with multiple paragraphs of text. Some words like "whereas" and "and" are visible, suggesting a legal or historical context.]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60795

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant 1629-2</b> d. STREET ADDRESS <b>113 68th Place,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Armando Joseph Di Gennaro</b>		4. DATE OF DEATH Month Day Year <b>January 19 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-16-25</b> 9. AGE (In years last birthday) <b>35</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder: Silver Spring Iron Works</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Mr. Nicola Di Gennaro</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Palladini</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW 2 Army</b>		16. SOCIAL SECURITY NO. <b>Wife: Mrs. Elvira Di Gennaro, same as above</b>	
17. INFORMANT <b>Wife: Mrs. Elvira Di Gennaro, same as above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>916.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Toxemia</b> (c) <b>Extensive Body Burns</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hr.</b> <b>4 days.</b> <b>9 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Welding - clearing fluid exploded. Burning over 1/2 body -</b>	
20c. TIME OF INJURY Month, Day, Year <b>1120 a.m. 1/10 1961</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Factory</b>	20f. (City or town) (County) (State) <b>Silver Spring Montgomery Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John G. Ball, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-23-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Hall</b>		22d. LOCATION (City, town, or country) (State) <b>Springfield, Va</b>	
23. FUNERAL DIRECTOR <b>R.A. Mattingly</b>		24a. REC'D BY REGISTRAR <b>Jan 23 '61</b>	
ADDRESS <b>R.A. Mattingly: 131 14th Street, S.E. Wash. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
00796

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>19½ yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>314 BREWSTER COURT</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>ELLSWORTH</b> Last <b>DIXON</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>18</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/19/94</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Architectural Engineer (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public Health Dept. U. S. Gov't.</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JAMES B. DIXON</b>				14. MOTHER'S MAIDEN NAME <del>UNKNOWN</del> <b>KATHERINE HOHNG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-52-2765</b>		17. INFORMANT Address <b>Mrs. May M. Dixon, 314 Brewster Court</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Silver Spring, Md.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>12 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-17</b> 19 <b>48</b> to <b>1-18</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>1-18</b> 19 <b>61</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Chas. W. Harnsberger</b>				22b. DATE SIGNED <b>1-19-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>CHAS. W. HARNBERGER</b>				22d. ADDRESS <b>4201 NEW HAMPSHIRE AVE NW</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/21/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BATES MEM. CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SNOW HILL, WORCESTER COUNTY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Harns</b>	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

804

00797

1. PLACE OF DEATH a. COUNTY <b>Montgomery Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>DC</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, Maryland</b>		c. LENGTH OF STAY IN 1b <b>1-week</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, DC</b>		47 X # 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oak Haven Nursing Home</b>		d. STREET ADDRESS <b>1908- 17th Street S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNIE M. DOERING</b>		4. DATE OF DEATH Month Day Year <b>Jan 9 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13- 1885</b>
9. AGE (In years last birthday) <b>75</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US. Gov.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jonas Doering</b>		14. MOTHER'S MAIDEN NAME <b>Helen V. Wagner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Helen V. Gibson</b>		Address <b>1908- 17th St. S.E. Wash., DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>(a) 48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1933</b> to <b>1/9</b> , 19 <b>61</b> , that (I) (we) lost saw the deceased alive on <b>1/8</b> , 19 <b>61</b> , and that death occurred at <b>12:10</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>R.C. Kirchner</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>R.C. KIRCHNER</b>		22d. ADDRESS <b>6480 N.H. Dr - Takoma Park Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Jan 11-61</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington National Switland, Maryland</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sinnott Bros 1661-9d Hope Rd S E</b>		25a. REC'D BY REGISTRAR <b>JAN 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. DATE	

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

805

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 21 Film 6279 1-25-61 et

60798

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>New Hersey</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b> d. STREET ADDRESS <b>200 Weequahic Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>(None)</b> Last <b>Dolgan</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1911</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Technologist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New Jersey</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Issac Dolgan</b>		14. MOTHER'S MAIDEN NAME <b>Gussie Mendelsohn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staphylococcus Septicemia</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dermatomyositis</b> DUE TO (c) <b>Carcinoma of the Breast</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 5 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 10, 1961</b> to <b>January 19, 1961</b> that (I) (we) last saw the deceased alive on <b>January 19, 1961</b> , and that death occurred at <b>9:05 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Daniel B. Drachman</b> M.D.		22b. DATE SIGNED <b>1/19/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Daniel B. Drachman, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 22, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>NEWARK N. J.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Drachman &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 23 '61</b>	
ADDRESS <b>3501-14 ST. N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

803

CERTIFICATE OF DEATH

THE [illegible] [illegible]

[illegible] [illegible]

[illegible] [illegible]

[illegible] [illegible]

[illegible] [illegible]

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[illegible] [illegible]

[illegible] [illegible]

[illegible] [illegible]

[illegible] [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

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306  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60799

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>57 Glen Echo Heights</u> d. STREET ADDRESS <u>15104 Wapahanna Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rudolph John Dominic</u>		4. DATE OF DEATH Month Day Year <u>1 19 1961</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year <u>7-15-1913</u>		9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>1 19</u>		11. IF UNDER 24 HRS. Hours Min. <u>19 61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housing</u>				11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Dominic</u>				14. MOTHER'S MAIDEN NAME <u>Julia Mendini</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>111-05-7199</u>				17. INFORMANT <u>Catherine M. (wife)</u> Address <u>same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>1 hr.</u> (c) <u>1 hr.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 hr.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-19-61</u>							
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				Address (Street, city, town, or county) <u>2224-Wis Ave Wash. DC</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan 23 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>									
23. FUNERAL DIRECTOR <u>H. Don. DeVol</u>				ADDRESS <u>2224-Wis Ave</u>				24a. REC'D BY REGISTRAR <u>JAN 23 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Catherine M. (wife)</u>							

100

Montgomery  
Baker

DOF

2 children  
Hospice

Robert & John

M  
W

Buller  
Honey

John

He was in the hospital (N.Y.C.) from October

7-12-13

Constitution

John

2104 Washington St

John's wife

Pauline

200  
SOCIAL EXAMINER'S CERTIFICATE OF DEATH



## CERTIFICATE OF DEATH

Reg. Dist. No.

00800

807

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL HALL NURSING HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 SILVER SPRING</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LOUETTA</b> Last <b>DONLEY</b>		4. DATE OF DEATH Month <b>1</b> - Day <b>31</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/77</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Goshen, Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Louis Christopher Wellner</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Jane Doughman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>444X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 16, 1959</b> , to <b>1-31-1961</b> that I last saw the deceased alive on <b>1-31-1961</b> and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry M. Lowden M.D.</b>		ADDRESS (Street, city or town, state) <b>5206 Norway Dr. Chevy Chase, Md.</b>	
PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>		DATE SIGNED <b>Cherry Chase, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans. &amp; Burial</b>		22b. DATE THEREOF <b>2/4/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>DAYTON MEM. PARK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>DAYTON, OHIO</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC. Raymond D. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

807



1951

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The text is mirrored and mostly illegible due to the quality of the scan.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

60801

308

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jo</b> Middle <b>Anne</b> Last <b>DONNELLY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-49</b>	
9. AGE (In years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Daniel J. DONNELLY, JR.</b>				14. MOTHER'S MAIDEN NAME <b>Eva J. JETER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>(F) Daniel J. Donnelly, same as #2 above</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>204.3</b> <i>septicemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>peritonitis</i> DUE TO (c) <i>acute lymphogenous leukemia</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>?</i> <i>3 weeks</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 19 60</b> to <b>January 5 19 61</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 5 19 61</b> , and that death occurred at <b>2:28AM</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert V. Rack</i>				22b. DATE SIGNED <b>1-5-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert V. RACK, LT, MC, USN</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-10-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Pearsons</i> <b>Pearsons Funeral Home, Falls Church, Va.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 10 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



809  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8-11111201 2-20-61 et

60862

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>100 North Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>David</b> Last <b>Dorsey</b>				4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1884 Oct. 28, 1885</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b>	IF UNDER 24 HRS. Hours <b>76</b> Min. <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Repair</b>		11. BIRTHPLACE (State or foreign country) <b>Poolesville, M d.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Anna Hamilton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Harold S. Dorsey 100 North Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Subtotal Gastrectomy for Carcinoma Stomach; Int. Obstruction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 17, 1960</b> to <b>Jan 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 2, 1961</b> , and that death occurred at <b>11:51 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John P. Habulin</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-3-61</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>1015 Spring St. Silver Spring, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lucien Park</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				ADDRESS <b>Rockville</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 9 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>			

CERTIFICATE OF DEATH

INVESTIGATION AT DEPARTMENT OF HEALTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

DATE

SIGNATURE OF PHYSICIAN

SIGNATURE OF DEATH REGISTRAR

*Presbyterian*

*stop*

*Booklet of death certificates, (Presbyterian Church, at Clinton)*

*Jan 2 1911*

*John D. H. H. H.*

*Jan 17 1911*

*1-3-11*

*1017 Spring St. 2nd Floor*



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00803

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selma Spring</u>		c. LENGTH OF STAY IN 1b <u>13 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Selma Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10216 Capital View Ave</u>				d. STREET ADDRESS <u>10216 Capital View Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Anthony Dore</u>		4. DATE OF DEATH <u>Jan 26 1961</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-21-22</u>		9. AGE (in years last birthday) <u>38 yrs</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Edw. Dore</u>		14. MOTHER'S MAIDEN NAME <u>Martha Sattler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES WW II</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Jett Dore (wife)</u>		Address <u>Ilum 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Myocardial Insufficiency</u>		(b) <u>Coronary Occlusion</u>		(c) <u>Coronary Atherosclerosis</u>		Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						Unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. <u></u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-26-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		Address (Street, city, town, or county) <u></u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/30/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jan 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
811 MEDICAL EXAMINER'S CERTIFICATE OF DEATH								C0804	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Rockville (rural)</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Seven Locks Road</u>					d. STREET ADDRESS <u>Seven Locks Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise Martin Dove</u>					4. DATE OF DEATH Month <u>Jan.</u> Day <u>25</u> Year <u>19 61</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/1/1885</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Clem Martin</u>					14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>Frances Curtis (daughter) Item 2</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschart</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1/25/61</u>				
					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park.,</u>			22d. LOCATION (City, town, or country) (State) <u>Muirkirk, Md.</u>		
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>					ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>

10-11-41

STATE OF TEXAS  
COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this 11th day of November, 1941, personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this 11th day of November, 1941.

Notary Public in and for the State of Texas

1

11 / 1

11, 1941

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MONTGOMERY COUNTY, MARYLAND											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>R.F. # 1 - Double Farm</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Helen Marion</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>10</u> Year <u>1961</u>				5. SEX <u>female</u>			
6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 17, 1915</u>		9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>				11. BIRTHPLACE (State or foreign country) <u>Canada</u>			
12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>				13. FATHER'S NAME <u>Charles Marion</u>				14. MOTHER'S MAIDEN NAME <u>Mae Hyland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u></u>				17. INFORMANT <u>Harry Reed</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u> DUE TO <u>970.2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u></u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reported taking 43-1 1/2 gr. Seconal cap at home</u>							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>			
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22. ACTUAL SIGNATURE <u>Frank J. Broschart</u>				23. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				24. DATE SIGNED <u>1-10-61</u>			
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				25b. DATE THEREOF <u>1/13/61</u>				25c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>			
25d. LOCATION (City, town, or country) <u>Rockville, Maryland</u>											
26. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>				26a. ADDRESS <u>Bethesda, Maryland</u>				26b. REC'D BY REGISTRAR <u>13 '61</u>			
26c. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>											

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
DIVISION OF LABORATORY AND MEDICAL SERVICES  
DIVISION OF MEDICAL EXAMINERS  
DIVISION OF VETERINARY MEDICINE  
DIVISION OF ZOOLOGICAL MEDICINE  
DIVISION OF PLANT MEDICINE  
DIVISION OF ENTOMOLOGY  
DIVISION OF MICROBIOLOGY  
DIVISION OF IMMUNOLOGY  
DIVISION OF PATHOLOGY  
DIVISION OF ANATOMY  
DIVISION OF PHYSIOLOGY  
DIVISION OF PHARMACOLOGY  
DIVISION OF TOXICOLOGY  
DIVISION OF CLINICAL MEDICINE  
DIVISION OF CLINICAL SURGERY  
DIVISION OF CLINICAL DENTISTRY  
DIVISION OF CLINICAL OPTHALMOLOGY  
DIVISION OF CLINICAL OTOLARYNGOLOGY  
DIVISION OF CLINICAL RADIOLOGY  
DIVISION OF CLINICAL NEUROLOGY  
DIVISION OF CLINICAL PSYCHIATRY  
DIVISION OF CLINICAL PEDIATRICS  
DIVISION OF CLINICAL GYNECOLOGY  
DIVISION OF CLINICAL OBSTETRICS  
DIVISION OF CLINICAL UROLOGY  
DIVISION OF CLINICAL NEPHROLOGY  
DIVISION OF CLINICAL HEPATOLOGY  
DIVISION OF CLINICAL GASTROENTEROLOGY  
DIVISION OF CLINICAL CARDIOLOGY  
DIVISION OF CLINICAL PULMONOLOGY  
DIVISION OF CLINICAL RHEUMATOLOGY  
DIVISION OF CLINICAL DERMATOLOGY  
DIVISION OF CLINICAL ALLERGOLOGY  
DIVISION OF CLINICAL IMMUNOLOGY  
DIVISION OF CLINICAL INFECTIOUS DISEASES  
DIVISION OF CLINICAL ONCOLOGY  
DIVISION OF CLINICAL TRANSPLANT MEDICINE  
DIVISION OF CLINICAL REPRODUCTIVE MEDICINE  
DIVISION OF CLINICAL ENDOCRINOLOGY  
DIVISION OF CLINICAL METABOLISM  
DIVISION OF CLINICAL NUTRITION  
DIVISION OF CLINICAL GERIATRICS  
DIVISION OF CLINICAL PALLIATIVE CARE  
DIVISION OF CLINICAL SUPPORT SERVICES  
DIVISION OF CLINICAL RESEARCH  
DIVISION OF CLINICAL EDUCATION  
DIVISION OF CLINICAL PRACTICE  
DIVISION OF CLINICAL MANAGEMENT  
DIVISION OF CLINICAL QUALITY IMPROVEMENT  
DIVISION OF CLINICAL PATIENT SAFETY  
DIVISION OF CLINICAL RISK MANAGEMENT  
DIVISION OF CLINICAL COMPLIANCE  
DIVISION OF CLINICAL ETHICS  
DIVISION OF CLINICAL LEGAL AFFAIRS  
DIVISION OF CLINICAL POLICY  
DIVISION OF CLINICAL STRATEGY  
DIVISION OF CLINICAL INNOVATION  
DIVISION OF CLINICAL TRANSFORMATION  
DIVISION OF CLINICAL REFORM  
DIVISION OF CLINICAL REVOLUTION  
DIVISION OF CLINICAL FUTURE  
DIVISION OF CLINICAL HOPE  
DIVISION OF CLINICAL DREAM  
DIVISION OF CLINICAL VISION  
DIVISION OF CLINICAL FAITH  
DIVISION OF CLINICAL LOVE  
DIVISION OF CLINICAL PEACE  
DIVISION OF CLINICAL JOY  
DIVISION OF CLINICAL GRATITUDE  
DIVISION OF CLINICAL KINDNESS  
DIVISION OF CLINICAL COMPASSION  
DIVISION OF CLINICAL EMPATHY  
DIVISION OF CLINICAL RESPECT  
DIVISION OF CLINICAL TOLERANCE  
DIVISION OF CLINICAL PATIENCE  
DIVISION OF CLINICAL HUMILITY  
DIVISION OF CLINICAL SINCERITY  
DIVISION OF CLINICAL INTEGRITY  
DIVISION OF CLINICAL HONESTY  
DIVISION OF CLINICAL COURAGE  
DIVISION OF CLINICAL STRENGTH  
DIVISION OF CLINICAL RESILIENCE  
DIVISION OF CLINICAL PERSEVERANCE  
DIVISION OF CLINICAL DETERMINATION  
DIVISION OF CLINICAL COMMITMENT  
DIVISION OF CLINICAL DEDICATION  
DIVISION OF CLINICAL DEVOTION  
DIVISION OF CLINICAL SACRIFICE  
DIVISION OF CLINICAL SERVICE  
DIVISION OF CLINICAL GIVING  
DIVISION OF CLINICAL RECEIVING  
DIVISION OF CLINICAL SHARING  
DIVISION OF CLINICAL Caring  
DIVISION OF CLINICAL SUPPORT  
DIVISION OF CLINICAL HELP  
DIVISION OF CLINICAL ASSISTANCE  
DIVISION OF CLINICAL GUIDANCE  
DIVISION OF CLINICAL DIRECTION  
DIVISION OF CLINICAL INSPIRATION  
DIVISION OF CLINICAL MOTIVATION  
DIVISION OF CLINICAL ENCOURAGEMENT  
DIVISION OF CLINICAL UPLIFTING  
DIVISION OF CLINICAL EMPOWERING  
DIVISION OF CLINICAL ENLIGHTENING  
DIVISION OF CLINICAL AWAKENING  
DIVISION OF CLINICAL REVIVALING  
DIVISION OF CLINICAL RESTORING  
DIVISION OF CLINICAL REPAIRING  
DIVISION OF CLINICAL REBUILDING  
DIVISION OF CLINICAL REFORMING  
DIVISION OF CLINICAL REVOLUTIONIZING  
DIVISION OF CLINICAL TRANSFORMING  
DIVISION OF CLINICAL REFORMING  
DIVISION OF CLINICAL REVOLUTIONIZING  
DIVISION OF CLINICAL TRANSFORMING

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Robert A. Thompson, M.D., M.P.H.  
Director, Division of Public Health  
Maryland State Department of Health  
100 North E Street  
Baltimore, Maryland 21201  
410-333-3333  
rthompson@mdhs.org



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

813

Item 3, -- File C280 2-3-61 et

Reg. Dist. No.

00806

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ROCKFORD</b> Last <b>DWYER</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>26,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Research Assoc.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Phillip N. Dwyer</b>		14. MOTHER'S MAIDEN NAME <b>Sidney Harvey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mrs. Elizabeth H. Dwyer</b>	
17. INFORMANT <b>Wife</b> Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/31/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JAN 30 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John, Anderson	
Sex		Male	
Age		23	
Date of Birth		Jan. 23, 1902	
Place of Birth		U.S.A.	
Marital Status		Single	
Occupation		Laborer	
Cause of Death		Typhoid Fever	
Place of Death		Suburban Hospital	
Date of Death		Jan. 23, 1902	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	
City		Baltimore	
State		Maryland	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MONTGOMERY STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00867

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>22 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>1 yr</u>				d. STREET ADDRESS <u>9303 Florin Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9303 Florin Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Arthur V. Englert Sr.</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-31-1902</u>	
9. AGE (in years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral director</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>The S.H. Hines Co.</u>		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Martin Englert</u>				14. MOTHER'S M maiden NAME <u>Emma Ireland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes</u>				16. SOCIAL SECURITY NO. <u>418-09-3945</u>		17. INFORMANT <u>May Englert</u> Address <u>Steu 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-18-61</u>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Prince Georges, Md.</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
Address <u>2901 14th St. N.W.</u>				DATE <u>JAN 23 '61</u>			
City <u>Washington 9, D.C.</u>							

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The S. S. White Co. Washington, D. C.  
100-2111-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

815

CERTIFICATE OF DEATH

Reg. Dist. No. 00808

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>45 Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5625 Oak Place</b>		d. STREET ADDRESS <b>5625 Oak Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>C</b> Last <b>Estes</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>22</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>David Estes</b>		14. MOTHER'S MAIDEN NAME <b>Sue Gibson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Anna S. Estes-wife-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>10 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/1</b> , 19 <b>60</b> , to <b>1/6/61</b> , 19 <b></b> , that I last saw the deceased alive on <b>1/6</b> , 19 <b>61</b> , and that death occurred at <b>9:30 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr Joseph Kenrick</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>6450 Wisconsin Ave, Bethesda, Md, 1/6/61</b>	
PHYSICIAN'S NAME (Type) <b>Dr JOSEPH KENRICK</b>		6450 Wisconsin Ave., Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/10/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JAN 10 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Department of Health of the State of Maryland, and that the same has been compared with the original and found to be a true and correct copy.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED <b>ROBERT A. KENNEDY</b>		SEX <b>MALE</b>		AGE <b>34</b>	
DATE OF DEATH <b>10/11/64</b>		PLACE OF DEATH <b>HOME</b>		COUNTY <b>ANNAPOLIS</b>	
TIME OF DEATH <b>10:15 PM</b>		CAUSE OF DEATH <b>HEART DISEASE</b>		MANNER OF DEATH <b>NATURAL</b>	
PLACE OF BIRTH <b>ANNAPOLIS, MARYLAND</b>		DATE OF BIRTH <b>10/11/30</b>		SEX <b>MALE</b>	
OCCUPATION <b>ATTORNEY</b>		EDUCATION <b>HIGH SCHOOL</b>		RELIGION <b>CATHOLIC</b>	
MARITAL STATUS <b>MARRIED</b>		DATE OF MARRIAGE <b>1958</b>		PLACE OF MARRIAGE <b>ANNAPOLIS, MARYLAND</b>	
NAME OF SPouse <b>JOAN KENNEDY</b>		DATE OF DEATH OF SPouse <b>1964</b>		PLACE OF DEATH OF SPouse <b>ANNAPOLIS, MARYLAND</b>	
NAME OF FATHER <b>JOHN KENNEDY</b>		DATE OF DEATH OF FATHER <b>1964</b>		PLACE OF DEATH OF FATHER <b>ANNAPOLIS, MARYLAND</b>	
NAME OF MOTHER <b>MARY KENNEDY</b>		DATE OF DEATH OF MOTHER <b>1964</b>		PLACE OF DEATH OF MOTHER <b>ANNAPOLIS, MARYLAND</b>	
NAME OF PHYSICIAN <b>DR. J. H. KENNEDY</b>		DATE OF DEATH OF PHYSICIAN <b>1964</b>		PLACE OF DEATH OF PHYSICIAN <b>ANNAPOLIS, MARYLAND</b>	
NAME OF NURSE <b>JOAN KENNEDY</b>		DATE OF DEATH OF NURSE <b>1964</b>		PLACE OF DEATH OF NURSE <b>ANNAPOLIS, MARYLAND</b>	
NAME OF BURIAL PLACE <b>ST. JOSEPH'S CATHEDRAL</b>		DATE OF BURIAL <b>10/11/64</b>		PLACE OF BURIAL <b>ANNAPOLIS, MARYLAND</b>	
NAME OF FUNERAL HOME <b>JOHN KENNEDY</b>		DATE OF FUNERAL <b>10/11/64</b>		PLACE OF FUNERAL <b>ANNAPOLIS, MARYLAND</b>	
NAME OF CEMETERY <b>ST. JOSEPH'S CATHEDRAL</b>		DATE OF CEMETERY <b>10/11/64</b>		PLACE OF CEMETERY <b>ANNAPOLIS, MARYLAND</b>	
NAME OF INTERVIEWER <b>JOHN KENNEDY</b>		DATE OF INTERVIEW <b>10/11/64</b>		PLACE OF INTERVIEW <b>ANNAPOLIS, MARYLAND</b>	
NAME OF WITNESS <b>JOHN KENNEDY</b>		DATE OF WITNESS <b>10/11/64</b>		PLACE OF WITNESS <b>ANNAPOLIS, MARYLAND</b>	
NAME OF SIGNER <b>JOHN KENNEDY</b>		DATE OF SIGNER <b>10/11/64</b>		PLACE OF SIGNER <b>ANNAPOLIS, MARYLAND</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00809

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8410 QUEEN ANNE DR</u>		d. STREET ADDRESS <u>8410 QUEEN ANNE DR</u>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Esther</u> Middle Last		4. DATE OF DEATH <u>JAN 11</u> 19 <u>61</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETI.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THEODORE ESTIER</u>		14. MOTHER'S MAIDEN NAME <u>IDA MORRE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>KATHERINE ESTIER - SILVER SPRING</u>		Address <u>8410 QUEEN ANNE DR</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>9 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 5, 1958</u> to <u>Jan. 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan. 5, 1961</u> , and that death occurred at <u>9:00</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u> M.D.		22b. DATE SIGNED <u>11 Jan 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		22d. ADDRESS <u>8801 Colesville Road, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>1-11-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lees Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Wash. D. C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees - Wash. D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 12 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

318

1. Name of deceased  
2. Date of death  
3. Place of death  
4. Cause of death  
5. Age at death  
6. Sex  
7. Color  
8. Marital status  
9. Occupation  
10. Education  
11. Religion  
12. Name of informant  
13. Signature of informant  
14. Signature of registrar  
15. Date of registration

1

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1- MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

817

CERTIFICATE OF DEATH

Reg. Dist. No. C0810

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Rockville</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>10411 Amherst Ave.,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Waverley Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eleano r</b> Middle <b>SHERMAN</b> Last <b>Ewing</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1875 Dec. 15, 1898</b>
9. AGE (In years last birthday) <b>84 85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Ewing</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
INFORMANT <b>Mr. Allwine, Waverley Sanitarium.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Hypoproteinemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Chronic Rehabilitation</b> (c) <b>Chronic Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October, 1960</b> , to <b>Jan 7, 1961</b> , that I last saw the deceased alive on <b>Jan 7, 1961</b> , and that death occurred at <b>5:30 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>10401 Knooks Rd. Jan 7 1961</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT T. THIBADEAU</b>		<b>Kennington, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/11/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC.</b>		24a. REC'D BY REGISTRAR <b>Jan 12 '61</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

817



Blank form area for the Certificate of Death, containing faint lines and text for data entry.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>7 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9910 LORAIN AVENUE</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>30 SILVER SPRING</b> d. STREET ADDRESS <b>19910 LORAIN AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>STANLEY LIVINGSTON FANT, SR.</b>						4. DATE OF DEATH Month <b>JAN.</b> Day <b>1</b> Year <b>1961</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/22/03</b>		9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. GOV'T. POST OFFICE</b>				11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE PAYNE FANT</b>						14. MOTHER'S MAIDEN NAME <b>BLANCHE MAY WELCH</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WW # 2 577-16-1503</b>		17. INFORMANT Address <b>Mrs. Blanche M. Welch, 9910 Lorain Ave. Silver Spring, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420-1</b> (c), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/2/61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>1/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		22d. LOCATION (City, town, or country) <b>ARLINGTON, VIRGINIA</b>			
23. FUNERAL DIRECTOR <b>RAYMOND E. PUMPHREY, INC.</b> <b>Raymond E. Pumphrey</b>						ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

100 SHILL  
NIGHTH HILL

818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: BOB LOUAIN AUSTIN  
AGE: 7 YEARS  
SEX: MALE  
RACE: WHITE

DATE OF DEATH: JAN. 21, 1932  
PLACE OF DEATH: ST. LOUIS, MO.

CAUSE OF DEATH: U. S. CIVIL  
MANNER OF DEATH: D.O.

DEATH CERTIFICATE  
ST. LOUIS, MO.

DEATH CERTIFICATE  
ST. LOUIS, MO.

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DEATH CERTIFICATE  
ST. LOUIS, MO.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

60812

819

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>50</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BLANCHE H. FEATHERSTONHAUGH</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>20,</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1892</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Marion, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John M. Hickman</b>		14. MOTHER'S MAIDEN NAME <b>Rose McKenna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Arthur Featherstonhaugh - Son</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>3 MRS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>POLYCYTHEMIA VERA</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>JAN 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>JAN 20, 1961</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John H. Touhy</b>		22b. DATE SIGNED <b>1-21-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. TOUHY</b>		22d. ADDRESS <b>7720 Wisconsin Ave., Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>DATE JAN 25 '61</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
820  
CERTIFICATE OF DEATH  
00813

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Route # 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>William</b> Last <b>Finneyfrock</b>				4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 10, 1902</b>	
9. AGE (In years last birthday) <b>58</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland Redland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ora F. Finneyfrock</b>				14. MOTHER'S MAIDEN NAME <b>Cora Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-05-5584</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>35 yrs.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 27, 1961</b> , to <b>January 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>January 15, 1961</b> , and that death occurred at <b>7:55AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert B. Scoggins</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>1/15/61</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert B. Scoggins M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institute of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-17-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>		23d. LOCATION (City, town, or county) (State) <b>Laytonsville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 19 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00814

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont. P. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lewisdale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San &amp; Hospital</i>		d. STREET ADDRESS <i>2004 Charleston Place</i>	
3. NAME OF DECEASED (Type or print) First <i>Clarence</i> Middle <i>Arthur</i> Last <i>Fletcher</i>		4. DATE OF DEATH Month <i>1</i> - Day <i>12</i> - Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-31-86</i>
9. AGE (In years and birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Va.</i>	
11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. d.</i>	
13. FATHER'S NAME <i>William Fletcher</i>		14. MOTHER'S MAIDEN NAME <i>Mary Janie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Washington Sanitarium &amp; Hosp. Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X Congestive heart failure &amp; Branchopneumonia</i> DUE TO (b) <i>3 days</i> DUE TO (c) <i>3 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Carcinoma of stomach.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12/30</i> 19 <i>60</i> to <i>1/12</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>1/12</i> 19 <i>61</i> , and that death occurred at <i>11:30</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>W.R. Moses</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>W.R. Moses</i>		22d. ADDRESS <i>1835 Eye St N.W.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>1/16/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CEAR HILL</i>	23d. LOCATION (City, town, or county) (State) <i>SUITLAND MD.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hankon Funeral Home</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Hanna</i>	
ADDRESS <i>3831 GA. AVE. N.W.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	
DATE <i>JAN 19 '61</i>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

2-31-86 74



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

822

00815

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sanit Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prin. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1659-2</u> d. STREET ADDRESS <u>2104 Cool Spring Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anna</u>		<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>13</u> Year <u>1961</u>		<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>Wh</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 5</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Germany</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>	
<b>13. FATHER'S NAME</b> <u>John Binder</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Marie Pauli</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <u>Helen L. Wilson Hyattsville Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4-34-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute congestive heart failure</u> DUE TO (c)																		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>3 1/4 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that</b> (1) (this hospital) attended the deceased from <u>1-7</u> , 19 <u>61</u> , to <u>1-13</u> , 19 <u>61</u> , that (1) (we) last saw the deceased alive on <u>1-13</u> , 19 <u>61</u> , and that death occurred at <u>2:33 PM</u> from the causes and on the date stated above.																					
<b>22a. SIGNATURE</b> <u>R. D. Bauer M.D.</u>										<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>1-13-61</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>R. D. BAUER, M.D.</u>										<b>22d. ADDRESS</b> <u>2513 Brooklodge Rd. Adelphi, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Jan 17, 1961</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>George Washington Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Hyattsville, Md.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gasch's Sons Hyattsville, Md.</u>										<b>25a. REC'D BY REGISTRAR</b> DATE <u>JAN 16 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Carling L. Evans</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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Miller

U S A

Germany

Own Home

homeless

Harold Paul

John Binder

John A. Simon - Hysterical

no

1

Jan 17, 1961 George Washington University, Washington, D.C.  
Jan 17, 1961  
Jan 17, 1961

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

823

## CERTIFICATE OF DEATH

Reg. Dist. No.

00816

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. LENGTH OF STAY IN 1b <u>8 1/2</u> YEARS <u>39 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANITARIUM</u>				d. STREET ADDRESS <u>1634 BELVEDERE BLVD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH BINDER GABERMAN</u>				4. DATE OF DEATH Month Day Year <u>JAN. 26 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 20, 1886</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>NOAH BINDER</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-09-6678 D</u>		INFORMANT <u>MRS N. JOEL</u>		Address <u>1634 BELVEDERE BLVD SS.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arterio Sclerosis -</u> <u>260X</u> DUE TO <u>Arterio Sclerosis C.V.R. disease -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Death's Malitus -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1-74</u> <u>3 yrs</u> <u>12 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-10-</u> , 19 <u>49</u> , to <u>1-26</u> , 1961, that I last saw the deceased alive on <u>1-25-</u> , 1961, and that death occurred at <u>4:00</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 - Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM BRAININ M.D.</u>				DATE SIGNED <u>Capital Hts Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-29-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B Danyausky &amp; Sons</u> ADDRESS <u>3501-14th St</u>				24a. REC'D BY REGISTRAR <u>FEB 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

253

1912

*[Faint, illegible text from the reverse side of the document is visible through the paper. The text appears to be a continuation of a certificate or a related document, mentioning names and dates.]*

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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AP

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00817

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>58 CABIN JOHN</u> d. STREET ADDRESS <u>7601 Cabin Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROSE EVELYN GAMBLE</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>26</u> Year <u>1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/18/77</u>		9. AGE (in years, last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shrillian Scientist practitioner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs. McAttee - 3835 Dupont St. Chevy Chase Md</u> Address <u>  </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. <u>  </u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-27-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>  </u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>		22d. LOCATION (City, town, or country) <u>Bladensburg RD. Md.</u>		(State) <u>  </u>			
23. FUNERAL DIRECTOR <u>Chry Chase Funeral Home Wash. DC</u>				ADDRESS <u>5103 Wase.</u>		24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>			
				DATE <u>JAN 31 '61</u>							





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
00818												
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1703 EAST-WEST HIGHWAY</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>CONTINENTAL HOTEL</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>MAURICE</b>			First Middle Last <b>GARBER</b>			4. DATE OF DEATH <b>JAN. 2 1961</b>			Month Day Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/20/02</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Justice</b>				11. BIRTHPLACE (State or foreign country) <b>Mass.</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Henry Garber</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Garber</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Torf Funeral Service</b> Address <b>1615 Beacon St, Boston,</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO										INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Frank J. Broschart</b>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>1/2/61</b>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>						22b. DATE THEREOF <b>1/2/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Torf Funeral Service</b>		22d. LOCATION (City, town, or country) (State) <b>Boston, Mass.</b>		
23. FUNERAL DIRECTOR <b>Georgy Muehleberg</b>						ADDRESS <b>4217-9-see</b>			24a. REC'D BY REGISTRAR <b>JAN 4 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

100-1115  
HEALTH UNIT

MONITORING

CLINICAL RECORD

100-1115-1115

LABORATORY

BARBER

12/10/62

58

Dept. of Justice, Bureau

Attorney

Henry H. H. H.

Elizabeth H. H.

Unknown

Unknown

For Funeral Service 1015 Beacon St., Boston

OF THE

12/10/62

12/10/62

For Funeral Service

Boston, Mass.

100-1115-1115

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **00810**

**326**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13,203 KARA LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GLANDVILLE</b> Middle <b>LaMOTTE</b> Last <b>GIBSON</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/22/09</b>
9. AGE (In years lost birthday) <b>51</b> yrs.		10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receiving Stock Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sears Roebuck Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank E. Gibson</b>		14. MOTHER'S MAIDEN NAME <b>Cora B. Reeling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-09-5634</b>	
17. INFORMANT <b>Mrs. Edna S. Gibson</b>		Address <b>13,203 Kara Lane</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 52</b> to <b>22 Jan</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>22 Jan</b> , 19 <b>61</b> , and that death occurred at <b>3:15 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		ADDRESS (Street, city or town, state) <b>906 Colsonville Rd Silver Spring Md</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>		DATE SIGNED <b>1/22/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/25/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. POMMERAY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>JAN 26 '61</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

CERTIFICATE OF DEATH

238

1911

DEPARTMENT OF HEALTH

WASHINGT

DATE

DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Signature of physician: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_

11. Date of registration: \_\_\_\_\_

12. Place of registration: \_\_\_\_\_

13. Name of registrar: \_\_\_\_\_

14. Name of physician: \_\_\_\_\_

15. Name of informant: \_\_\_\_\_

16. Name of informant: \_\_\_\_\_

17. Name of informant: \_\_\_\_\_

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19. Name of informant: \_\_\_\_\_

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21. Name of informant: \_\_\_\_\_

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100. Name of informant: \_\_\_\_\_

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

60820

827

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>5813 Greenlawn Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Mark</b> Middle <b>Clarence</b> Last <b>GILCHRIST</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>11</b> Year <b>1961</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-59</b>	9. AGE (In years lost birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Argentina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David M. GILCHRIST</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Maie RITTER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>(F) David M. Gilchrist, same as #2 above</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abscess, brain, organism undetermined</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital Heart Disease, Cyanotic</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Jan. 9 1961</b> to <b>Jan. 11 1961</b> , that <del>he</del> (we) last saw the deceased alive on <b>Jan. 11 1961</b> , and that death occurred at <b>6:50AM</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert V. Rack</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. Rack, LT, MC, USN</b>				22d. ADDRESS <b>u. s. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Randallstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				25a. REC'D BY REGISTRAR <b>JAN 13 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	
<b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>							

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237

CERTIFICATE OF DEATH

U. S. Naval Hospital, Bethesda, Md.  
Patient: David M. GILCHRIST  
Date of Birth: 2-11-32  
Date of Death: 1-14-50  
Cause of Death: Coronary Heart Disease, Chronic  
Place of Birth: Argentina  
Occupation: Doctor  
Signature: Roberto V. Hack, Jr., M.D., U.S.N.  
Date: 1-14-50  
Location: U. S. Naval Hospital, Bethesda, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

828

60821

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pri. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park</u>		c. LENGTH OF STAY IN 1b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Balin</u> First Middle Last <u>Gleeson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-61</u>
9. AGE (In years last birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Francis Xavier Gleeson</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Ann Ellis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother's chart</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature + prolonged</u> <u>750X</u> DUE TO <u>anencephalic development &amp; meningocele</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>meningocele</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12:45 P.M. 1-2-61</u> to <u>12:50 P.M. 1-2-61</u> , that (I) (we) last saw the deceased alive on <u>1-2-61</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul E. Egan</u> M.D.		22b. ADDRESS <u>6727-16th St. S.E. Wash. D.C.</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL E. EGAN M.D.</u>		22d. DATE SIGNED <u>1-2-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-4-61</u>		23b. DATE THEREOF <u>1-4-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>		23d. LOCATION (City, town or county) (State) <u>WASH. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hawthorne Funeral Home</u> ADDRESS <u>-3831-GA Ave. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 10 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

2075242 XVD



CERTIFICATE OF DEATH

858

1949 - August 1st

James Earl Ray  
Born 5-5-28  
Died 4-4-68  
Cause of Death: Suicide  
Place of Death: London, England

1949 - August 1st

James Earl Ray

1949 - August 1st

James Earl Ray

1949 - August 1st

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

829 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00822

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY in 1b <b>27 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8113 GROVE STREET</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>24 SILVER SPRING</b> d. STREET ADDRESS <b>1 8113 GROVE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>NORMA</b>		First <b>NORMA</b> Middle <b>-</b> Last <b>GOLDSTEIN</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>7</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>3/22/05</b>		9. AGE (in years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> IF UNDER 24 HRS. Hours <b>5</b> Min. <b>5</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK CITY, N.Y.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HARRY</b>		14. MOTHER'S MAIDEN NAME <b>CLARA (Unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Philip R. Goldstein, 8113 Grove Street Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage and laceration</b> DUE TO (b) <b>bullet wound thru skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>976X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflecting bullet thru skull</b>					
20c. TIME OF INJURY Hour a.m. <b>9:22am</b> Month, Day, Year <b>Jan. 7 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>			
20f. (City or town) <b>Silver Spring, Mont. Co., Md.</b>		(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. <b>FRANK J. BROSCART</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1/7/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 9, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Mem. Park</b>			
22d. LOCATION (City, town, or country) (State) <b>Falls Church, Va.</b>		23. FUNERAL DIRECTOR <b>Goldberg Funeral Home 4217 9th Street B.W.</b>					
24a. REC'D BY REGISTRAR <b>JAN 10 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

100-111111  
DEATH CERTIFICATE

82-111111

DEATH CERTIFICATE

111111

NAME OF DECEASED  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SEX  
RACE  
RELIGION  
EDUCATION  
OCCUPATION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS

1

NAME OF DECEASED  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SEX  
RACE  
RELIGION  
EDUCATION  
OCCUPATION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS

NAME OF DECEASED  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SEX  
RACE  
RELIGION  
EDUCATION  
OCCUPATION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS

830

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>21 Days</b>				3. STREET ADDRESS <b>1821 Ontario Place, N.W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Mary</b> Middle <b>Alice</b> Last <b>Gooding</b>		4. DATE OF DEATH		Month <b>January</b> Day <b>2</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 7, 1920</b>		9. AGE (In years lost birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Currence</b>				14. MOTHER'S MAIDEN NAME <b>Ella Glenn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-28-8144</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bilateral ureteral obstruction</b> DUE TO (c) <b>Carcinoma of the cervix</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3-4 weeks</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 12, 19 60</b> to <b>January 2, 19 61</b> , that I last saw the deceased alive on <b>January 2, 19 61</b> , and that death occurred at <b>11:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>1/3/61</b> ACTUAL SIGNATURE <b>J. W. Bains M.D.</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>JERRY W. BAINS, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/5/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		22d. LOCATION (City, town, or county) (State) <b>Highland Park, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Lisker</b>				ADDRESS <b>1432 You Street, N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 6 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





DISTRICT OF COLUMBIA: S. S.

WE/I,

upon our/my oath do depose and say: that, Mary Alice Gooding

who died January 2, 1961

in the District of Columbia

was our/my Wife

; and, that for a long time prior to his/her death was

known and referred to as Alice Gooding

, and that Mary Alice Gooding

and Alice Gooding

is one and the same person.

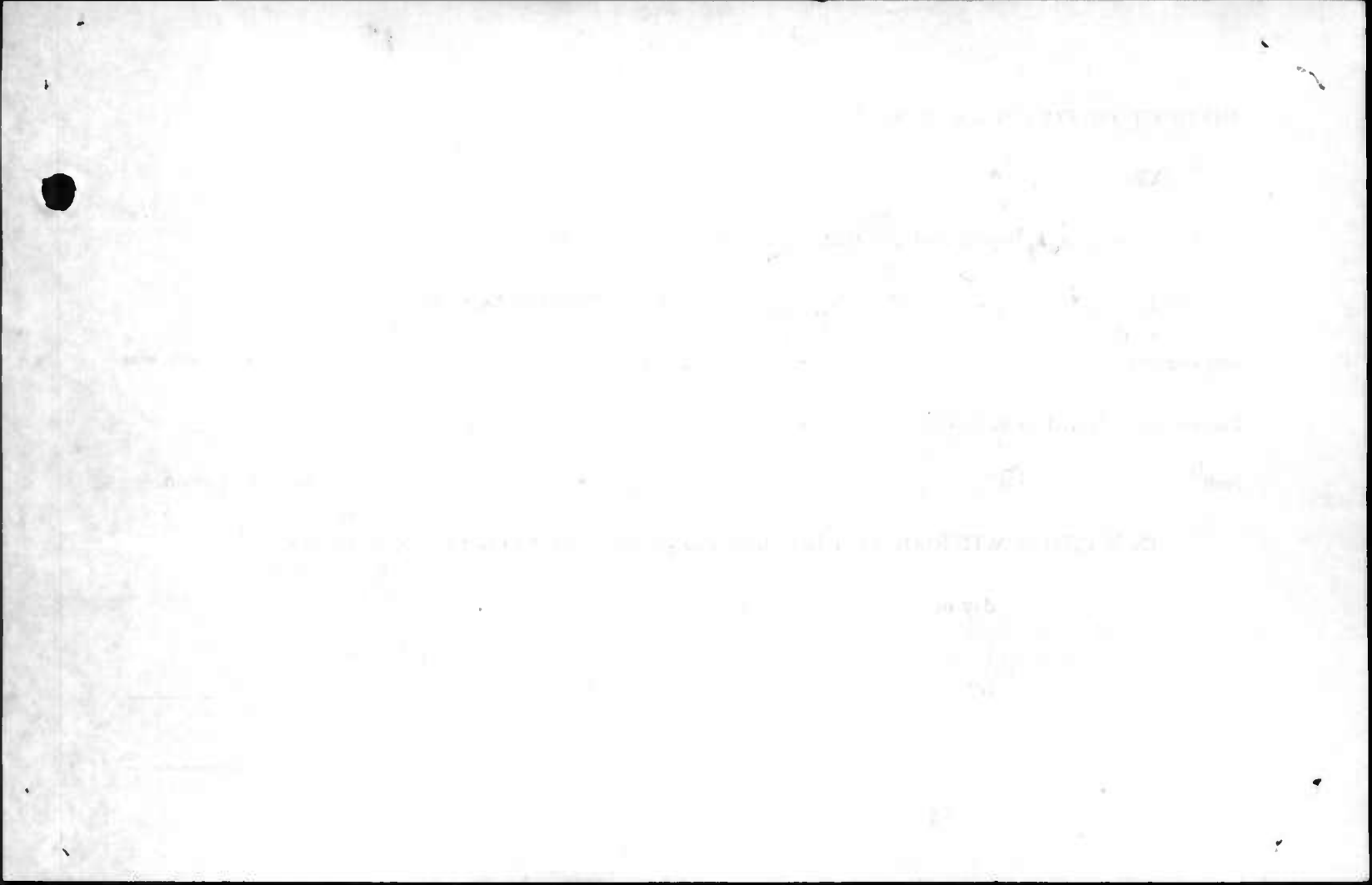
IN WITNESS WHEREOF we/I have hereunto set our hands and seal in duplicate, this 4<sup>th</sup>

day of Jan 19 61  
SUBSCRIBED AND SWORN TO  
BEFORE ME THIS 4<sup>th</sup> DAY

OF Jan 19 61  
Herbert R. Buschmann  
NOTARY PUBLIC D. C.

MY COMMISSION EXPIRES MARCH 14, 1962

Mary Alice Gooding



1. *[Handwritten mark]*  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

831

00824

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Pk md</u> c. LENGTH OF STAY in 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San &amp; Hosp</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1224 Blair Mill Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joyce Kay Goodwin</u>		<b>4. DATE OF DEATH</b> <u>1 20 1961</u>	
<b>5. SEX</b> <u>F.</u>	<b>6. COLOR OF RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Aug. 4-60</u>
<b>9. AGE</b> (In years last birthday) <u>1</u> <b>IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>17</u> <b>IF UNDER 24 HRS.</b> Hours <u>17</u> Min. <u>17</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Mont Co. md</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Mr. William E. Goodwin</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Ruby K. Mums</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Mr. William E. Goodwin</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 475X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Upper respiratory infection</u> (c) <u>Upper respiratory infection</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>10 min</u> <u>2 days</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour e.m. <u>19</u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from <u>1/18</u>, 19<u>61</u>, to <u>1/18</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>1/18</u>, 19<u>61</u>, and that death occurred at <u>2 AM</u>, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>James R. Coleman M.D.</u> M.D.		<b>22b. DATE</b> <u>1/20/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JAMES R. COLEMAN</u>		<b>22d. ADDRESS</b> <u>733 Sligo Ave., Silver Spring, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>1/23/61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ARLINGTON NATIONAL CEMETERY</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>ARLINGTON, VIRGINIA</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Dumphrey, Inc.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 25 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>			

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

Montgomery Co. Medical Examiner notified and released to hospital.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
832 CERTIFICATE OF DEATH 00825										
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>DOA</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>3402 McComas Ave.</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Clayton</b> Middle <b>William</b> Last <b>GRAY</b>					4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-27-00</b>		9. AGE (In years last birthday) <b>60</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Clark GRAY</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth (unknown)</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT <b>(S) Clayton A. Gray, 2300 Blueridge Ave. Wheaton, Md.</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction myocardium</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) <del>this person</del> attended the deceased from <b>DOA</b> <b>9:45 PM</b> to <b>DOA</b> 19 <b>61</b> , that (I) <del>was</del> last saw the deceased alive on <b>DOA</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.										
22a. SIGNATURE <i>Paul G. Linaweaver</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-1-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Paul G. LINAWEAVER, LT, MC, USN</b>					22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/3/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY</b> <b>Annapolis Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Pumphrey</i>					ADDRESS <b>Silver Spring, Md.</b>		REC'D BY REGISTRAR <b>DATE FEB 7 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	
W. E. Pumphrey Funeral Home, 8434 Georgia Ave.										

CENTRAL OFFICE OF DATA

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4, may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-10  
15M-9-59

833

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00826

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEO.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marilyn</u> Middle <u>Christine</u> Last <u>Greeley</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-29-60</u>
9. AGE (In years last birthday) yrs. <u>4</u> Months <u>10</u> Days <u>16</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>16</u> Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Greeley</u>		14. MOTHER'S MAIDEN NAME <u>Marilyn P. Cheek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father</u> Address <u>as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Interstitial Pneumonia, severe, hemorrhagic</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe acute cerebral edema</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/15/61</u> 19 <u>61</u> to <u>5:50 PM 1/16/61</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/15/61</u> 19 <u>61</u> , and that death occurred at <u>5:50 PM</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Winston E. Cochran M.D.</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 1/16/61 SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WINSTON E. COCHRAN</u>		22b. DATE <u>1/16/61</u>	
22d. ADDRESS <u>927 Pershing Dr., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPKIN INC. Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>JAN 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2875192XV5

CERTIFICATE OF DEATH

1912

1912

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of birth  
7. Place of death  
8. Cause of death  
9. Signature of physician  
10. Signature of registrar

11. Name of informant  
12. Address of informant  
13. Signature of informant  
14. Date of registration  
15. Registrar's name  
16. Registrar's address  
17. Registrar's signature  
18. Registrar's date

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 334 CERTIFICATE OF DEATH

Reg. Dist. No.

00827

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>North Carolina</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>33 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raleigh</u> 70X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>2709 Saint Mary's Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>Ellen</u> Last <u>Hamlin</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 20, 1951</u> 9. AGE (In years last birthday) <u>9</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W. Fred Hamlin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Katherine Kelley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia and lung abscess</u> 587.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cystic fibrosis</u> DUE TO Life (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 6, 1960</u> to <u>January 8, 1961</u> , that I last saw the deceased alive on <u>January 8, 1961</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>1/8/61</u> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <u>William O. Jones</u>		M.D. <u>The Clinical Center</u>		DATE SIGNED <u>1/8/61</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM O. JONES, M.D.</u>		M.D. <u>The Clinical Center</u>		DATE SIGNED <u>1/8/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 1-9-61</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Montlawn Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Raleigh, North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 16 61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Item 18 Form 280 2-7-61											
MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
835 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00828											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> c. LENGTH OF STAY IN 1b <b>3 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3108 Parker Ave.</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> d. STREET ADDRESS <b>3108 Parker Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Theodore T. Hanford, Jr.</b>			4. DATE OF DEATH <b>1 27 19 61</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>12/9/11</b>			9. AGE (In years last birthday) <b>49</b> yrs.			10. IF UNDER 1 YEAR Months Days		
11. BIRTHPLACE (State or foreign country) <b>U.S. Gov.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Theodore T. Hanford, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Eva Miller</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16. SOCIAL SECURITY NO. <b>WW # 2</b>			17. INFORMANT <b>Mrs. C. Virginia Hanford, 3108 Parker Ave.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0 Fat embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hepatic Fatty metamorphosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury In Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			22b. DATE THEREOF <b>1/31/61</b>			22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>			22d. LOCATION (City, town, or country) (State) <b>ARLINGTON, VIRGINIA</b>		
23. FUNERAL DIRECTOR <b>WALTER E. PUMPHREY, INC.</b>			24a. REC'D BY REGISTRAR <b>FEB 3 '61</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			25. CHIEF MEDICAL EXAMINER <b>Frank J. Broschart</b>		
26. DEPUTY MEDICAL EXAMINER <b>FRANK J. Broschart</b>			27. DATE SIGNED <b>1-27-61</b>			28. ADDRESS (Street, city, town, or county)			29. SIGNATURE		

MEDICAL CERTIFICATION

FOR THE  
RECORDING

1008 1008

1008 1008

U.S. Gov.

U.S. Gov.

U.S. Gov.

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U. S. VETERAN'S SERVICE, 3108 1008

WASHINGTON, D. C. 20540

1008 1008



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
68829

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>West. San.</u>				d. STREET ADDRESS <u>14004 Wexford</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>nmn</u> Last <u>HANKIN</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>17</u> Year <u>1961</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-81</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ruma</u>		11. BIRTHPLACE (County & State, or foreign country) <u>America</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>ISRAEL HANKIN</u>		14. MOTHER'S MAIDEN NAME <u>Michelle Lillian</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>p-t hosp record.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>154 X</u> DUE TO <u>Obstructed left ventr</u> Conditions, if any, which gave rise to immediate cause (b) <u>constriction of heart</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 2, 1961</u> , to <u>January 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>January 17, 1961</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Arthur J. Willets</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILLETS</u>				22d. ADDRESS <u>909 - Pershing Dr. Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 19, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baron Horsh Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Staten Island, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Willets</u>		ADDRESS <u>354 Carroll St. 22</u>		25. REC'D BY REGISTRAR <u>JAN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2080

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Received of  
Arthur G. Winters  
the sum of \$100.00

X

Arthur G. Winters

Arthur G. Winters 101-101-101-101

Arthur G. Winters 101-101-101-101

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

837

CERTIFICATE OF DEATH

60830

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>37 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>723 7th St., S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>Thelma</b> Middle <b>Mildred</b> Last <b>HARKINS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1961</b>								
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-3-21</b>	9. AGE (In years last birthday) <b>39</b> yrs.	10. IF UNDER 1 YEAR Months <b>39</b>	11. IF UNDER 24 HRS. Days <b>39</b>	12. IF UNDER 24 HRS. Hours <b>39</b>	13. IF UNDER 24 HRS. Min. <b>39</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Robert WYNN</b>		14. MOTHER'S MAIDEN NAME <b>Bertha F. TAYLOR</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchial asthma, chronic</b> DUE TO (c) <b>30 yrs.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>30 yrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mitral and aortic valvulitis, old, undetermined etiology</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>Dec. 15</b> <b>1960</b> to <b>Jan. 21</b> <b>1961</b> , that <b>he</b> (we) last saw the deceased alive on <b>Jan. 21</b> <b>1961</b> , and that death occurred at <b>11:55 AM</b> , from the causes and on the date stated above.								22b. DATE SIGNED <b>1-21-61</b>		
22a. SIGNATURE <b>D. L. KELLEY, LT, MC, USN</b>		22c. PHYSICIAN'S NAME (Type) <b>D. L. KELLEY, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE SIGNED <b>1-21-61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-26-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland Road, P.G.Co., Md.</b>		23e. REC'D BY REGISTRAR <b>DATE JAN 25 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. CHAMBERS</b>		24b. ADDRESS <b>517 11th. ST. S.E. WASH. DC.</b>		24c. REC'D BY REGISTRAR <b>DATE JAN 25 '61</b>		24d. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		24e. DATE <b>1-25-61</b>		24f. SIGNATURE <b>Arthur L. Thomas</b>

NAME	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF INTERVIEW	INTERVIEWER
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.
Robert W. Hines	1-1-21	1-1-21	U.S. Naval Hospital, Bethesda, Md.	U.S. Naval Hospital, Bethesda, Md.	Myocardial infarction, chronic	Jan. 21, 1921	U.S. Naval Hospital, Bethesda, Md.

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MONTGOMERY  
OLNEY  
MONTGOMERY GENERAL HOSPITAL  
CAROLYN Howard  
FEMALE  
WHITE  
Teacher  
HENRY HOWARD  
no  
none  
HOSPITAL RECORDS, OLNEY, MD.  
Multiple Myeloma  
to metastasis  
5 yr  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  
20d. INJURY OCCURRED While at work ☐ Not while at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)  
21. I certify that (I) (this hospital) attended the deceased from Oct 1959 to Jan 1961, that (I) (we) lost saw the deceased alive on Jan 10 1961, and that death occurred at 1:45 PM, from the causes and on the date stated above.  
22a. SIGNATURE  
22c. PHYSICIAN'S NAME (Type)  
A. D. BONIFANT, M. D.  
22b. DATE SIGNED  
22d. ADDRESS  
SANDY SPRING, MD.  
23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial  
23b. DATE THEREOF  
1-13-60  
23c. NAME OF CEMETERY OR CREMATORY  
St. John's  
23d. LOCATION (City, town, or county) (State)  
Olney, Mont. Md.  
24. FUNERAL DIRECTOR'S SIGNATURE  
Francis Barber  
Laytonsville, Md.  
25a. REC'D BY REGISTRAR  
DATE JAN 13 '61  
25b. REGISTRAR'S SIGNATURE  
Arthur S. House

00851

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CAROLYN Howard</b>				4. DATE OF DEATH <b>JANUARY 10 19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/30/1900</b>	
9. AGE (In years lost birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Teaching</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>HENRY HOWARD</b>				14. MOTHER'S MAIDEN NAME <b>MARY FLORENCE JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> DUE TO <b>to metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 yr</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1959</b> to <b>Jan 1961</b> , that (I) (we) lost saw the deceased alive on <b>Jan 10 1961</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. D. Bonifant</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b> 22d. ADDRESS <b>SANDY SPRING, MD.</b> 22b. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-13-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		23d. LOCATION (City, town, or county) (State) <b>Olney, Mont. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Barber</b> ADDRESS <b>Laytonsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

CERTIFICATE OF DEATH

938



Form with fields for personal and medical information, including name, date of birth, sex, race, marital status, occupation, and cause of death. The text is mirrored and difficult to read.

Form with fields for medical history, including previous illnesses, surgical operations, and a section for the attending physician's signature and seal. The text is mirrored and difficult to read.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
839  
CERTIFICATE OF DEATH

00832

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>20 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Country Hills, Fairfax</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>207 Andover Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Helen Marie HAWKES</b>		4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>19 61</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-10</b>	9. AGE (In years lost birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dennis BARRY</b>			14. MOTHER'S MAIDEN NAME <b>Margaret RICE</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(H) Wm. M. Hawkes, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cirrhosis of liver</b> DUE TO (c) <b>unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 weeks</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 19 19 60</b> to <b>Jan. 8 19 61</b> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Jan. 8 19 61</b> , and that death occurred at <b>2:40AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>F. H. O'Connell</b>		22b. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		22c. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LCDR, MC, USN</b>		22d. DATE SIGNED <b>1-8-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		23b. DATE THEREOF <b>1-13-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pumphrey Funeral Home, Bethesda, Md.</b>				25a. REC'D BY REGISTRAR <b>Jan 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

U.S. DEPARTMENT OF HEALTH  
BUREAU OF VETERANS  
OFFICE OF THE CHIEF OF BUREAU

3183

Country Hills, Fairfax  
Virginia

SCJ Andover Drive  
U. S. Naval Hospital

January 8  
HAWKES  
Helen

20  
8-10-10  
Catheterization of bladder

New Jersey  
Hawesville

NEWARK, N.J.  
Dennis Barry

(P) W. M. Hawes, same as above  
None

Hepatic Insufficiency

Catheter of liver

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

Dec. 19  
Jan. 8

1-8-10

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

840

CERTIFICATE OF DEATH

Reg. Dist. No.

00833

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ropine Rest Home</b>		d. STREET ADDRESS <b>3803 Thornapple Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NANCY</b> Middle <b>KENNEDY</b> Last <b>HEAP</b>		4. DATE OF DEATH <b>January 15, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/13/1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Peter Kennedy</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Hazelett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Earl N. Heap, Jr. Item # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis.</b> <b>332x</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 + days</b> <b>2 + yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture R. thigh 24 Dec 60.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Fell reaching over chair</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>6-DEC-24-60</b> Hour <b>1:30 p.m.</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Potomac Mont. Md.</b>	
21. I certify that I attended the deceased from <b>1958</b> , to <b>15 JAN 1961</b> , that I last saw the deceased alive on <b>14 Jan 1961</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. H. Richwine</b> M.D.		ADDRESS (Street, city or town, state) <b>5522 Western Ave., Chevy Chase, Md.</b> DATE SIGNED <b>1/15/61</b>	
PHYSICIAN'S NAME (Type) <b>A. H. Richwine</b>		<b>5522 Western Ave. Chevy Chase, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/17/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>Funeral Home 1331 E. Montgomery Ave. Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 17 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

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FOR STATE  
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
08834											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>57 Rockville</i>				d. STREET ADDRESS <i>1 Sugarland Road.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lawrence Augusta Hebron</i>				4. DATE OF DEATH Month Day Year <i>Jan. 20 1961</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 11, 1903</i>		9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Carter's 52nd &amp; Gravel</i>				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Hebron</i>				14. MOTHER'S MAIDEN NAME <i>?</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>213-16-2023</i>				17. INFORMANT <i>Ada Hebron / same as above.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Acute Myocardial Insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Coronary Arteriosclerosis</i> (c) <i>Sudden</i> INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <i>Sugarland</i>				(County) <i>md.</i>				(State) <i>md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John E. Ball</i>				M.D. <i>John G. BALL</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>John G. BALL</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <i>1/20/61</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				22b. DATE THEREOF <i>1-25-61</i>				22c. NAME OF CEMETERY OR CREMATORY <i>St. Paul</i>			
22d. LOCATION (City, town, or country) <i>Sugarland, Md.</i>				(State) <i>md.</i>							
23. FUNERAL DIRECTOR <i>Robert L. Snowden</i>				ADDRESS <i>Rockville, Md.</i>				24a. REC'D BY REGISTRAR <i>Jan 26 '61</i>			
24b. REGISTRAR'S SIGNATURE <i>Charles L. Kiser</i>											





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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
842 CERTIFICATE OF DEATH 00835

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>22 HRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELLE</b> Middle <b>P.</b> Last <b>HELPHENSTINE</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>12</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/1882</b>
9. AGE (In years lost birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSEPH J. PRINTUP</b>		14. MOTHER'S MAIDEN NAME <b>LURA T. HOSS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS,</b>		Address <b>OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Atherosclerotic Cardiovascular Disease - Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 12, 1960</b> to <b>Jan. 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan. 12, 1961</b> , and that death occurred at <b>12 M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. A. Linthicum, M.D.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>1/12/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. A. LINTHICUM, M. D.</b> 22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/14/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 16 '61</b>	
ADDRESS <b>1331 E. Montg. Ave., Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Carthur S. Kenna</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

843  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		29	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>711 Wayne Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Elizabeth Hennessy</u>				4. DATE OF DEATH Month Day Year <u>Jan 1 1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-9-76</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Robert Mc Adams</u>				14. MOTHER'S MAIDEN NAME <u>Mary Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cardiac Decompensation</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>Many years</u> <u>" "</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> to <u>Jan 1 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 31 1960</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Merrill M. Cross</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>				22d. ADDRESS <u>8248 Longview Ave Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. POMPHREY, INC. Raymond A. Giska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawt</u>	

1929

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
344  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00857

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY <b>Wallins Creek</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>19 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wallins Creek</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>			d. STREET ADDRESS <b>Box 335</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lawrence</b> Middle <b>(none)</b> Last <b>Hensley</b>			4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 15, 1922</b>	9. AGE (In years lost birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months <b>38</b> Days <b>3</b> Hours <b>55</b> Min. <b>X-3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Joe Hensley</b>		
14. MOTHER'S MAIDEN NAME <b>Addie Pope</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		
16. SOCIAL SECURITY NO. <b>400-26-0126</b>			17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>204.3</b> IMMEDIATE CAUSE (a) <b>Gram Negative Septicemia</b> DUE TO (b) <b>Necrotizing Proctitis</b> DUE TO (c) <b>Acute Lymphocytic Leukemia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Weeks</b> <b>1 1/2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 8, 1961</b> to <b>January 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>January 27, 1961</b> , and that death occurred at <b>8:25 a.m.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Edward E. Morse</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD E. MORSE, MD.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>1/28/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>--</b>	
23d. LOCATION (City, town, or county) <b>Harlan, Kentucky</b>		23e. (State) <b>Kentucky</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St. N.W.</b>		ADDRESS <b>Washington 9, D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 30 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert S. Hines</b>		25c. (State) <b>Kentucky</b>			

CERTIFICATE OF DEATH

248

Deceased's Name

Age

Sex

Date of Death

Place of Birth

Place of Death

Cause of Death

Time of Death

Place of Death

Signature

Signature

Signature

Signature

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

**845**

**00833**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLMAR MANOR 184-4-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				d. STREET ADDRESS <u>3403 - 43<sup>rd</sup> Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Martha</u> Middle <u>Jeannette</u> Last <u>Hill</u>		4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 Oct 1889</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John W. HANES</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harry Hill Colmar Manor, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombophlebitis</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1/7</u> 19 <u>61</u> , to <u>1/8</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> 19 <u>61</u> , and that death occurred at <u>12</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald Nelson</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/8/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>		22d. ADDRESS <u>10620 Georgia Ave, Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) <u>Colmar Manor Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 13 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

CERTIFICATE OF DEATH

DECEASED

RESIDENT

DATE OF DEATH

John Nelson

WITNESSES

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

846

00839

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frackville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>13 N. 5th. Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Hinkel</b>				4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1893</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard L. Bevan</b>				14. MOTHER'S MAIDEN NAME <b>Ella Thursby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>J.B. Robertson - Valley Drive, Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Essential Hypertension</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 18, 1961</b> to <b>Jan 20, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Jan. 19, 1960</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William Frank</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM FRANK, M.D.</b>				22d. ADDRESS <b>544 W. MONTGOMERY AVE. ROCKVILLE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frackville, Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Humphrey</b>				25a. REC'D BY REGISTRAR <b>DATE JAN 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

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CERTIFICATE OF DEATH

828

For use in the State of Tennessee  
County of \_\_\_\_\_  
City of \_\_\_\_\_  
I, \_\_\_\_\_, Registrar of the Health Department,  
do hereby certify that \_\_\_\_\_  
born \_\_\_\_\_  
died \_\_\_\_\_  
at \_\_\_\_\_  
on \_\_\_\_\_  
at the age of \_\_\_\_\_ years.

Witness my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Registrar

Health Department

Attest my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

County Clerk

I, \_\_\_\_\_, Mayor of the City of \_\_\_\_\_, do hereby certify that \_\_\_\_\_  
born \_\_\_\_\_  
died \_\_\_\_\_  
at \_\_\_\_\_  
on \_\_\_\_\_  
at the age of \_\_\_\_\_ years.

no

Printed and Published by the State of Tennessee, Nashville, Tenn.

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TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

347

## CERTIFICATE OF DEATH

Reg. Dist. No.

60840

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13,402 KEATING STREET		d. STREET ADDRESS 13,402 KEATING STREET	
3. NAME OF DECEASED (Type or print) First Middle Last Emma LEE Hoffman		4. DATE OF DEATH Month Day Year January 27 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/82
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Accounting Dept.		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop Dept. Store	
11. BIRTHPLACE (State or foreign country) Louisa County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WILLIAM WOOLFOLK		14. MOTHER'S MAIDEN NAME MARTHA A. BIBB	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 518-12-4316-A	
17. INFORMANT Mrs. Geo. L. Ronk, 13,402 Keating St.		Address Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 463x Pulmonary Embolism DUE TO (b) Phlebo-Thrombosis in calves Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Infection 3-4 times previously		INTERVAL BETWEEN ONSET AND DEATH 20 min 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to 27 Jan, 1961, that I last saw the deceased alive on 25 Jan, 1961, and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Merton L. White		DATE SIGNED 11/34 Georgia Ave Wash 27 Jan 61	
PHYSICIAN'S NAME (Type) MERTON L. WHITE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/30/61	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE JAN 31 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			





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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
848 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
60841

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Lititz</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lititz</b> d. STREET ADDRESS <b>24 S. Ally</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles Rodney HORNBERGER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-29-41</b>	
9. AGE (in years last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b>		11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>19</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>			
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Hornberger</b>				14. MOTHER'S MAIDEN NAME <b>Doris H. Adams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes 7/59 to DOD</b>				16. SOCIAL SECURITY NO. <b>173 32 0447</b>			
17. INFORMANT <b>Official Navy Records</b>				Address			
18. CAUSE OF DEATH (Enter only one cause, or line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>laceration and contusion, brain with intra-cranial hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Basal skull fracture</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by AB&amp;W Bus while crossing street</b>			
20c. TIME OF INJURY Month, Day, Year <b>1005 Hour 10:05 p.m. 1-23 19 61</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street-Columbia Pike</b>				20f. (City or town) (County) (State) <b>Arlington Virginia</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. BROSCHART, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1-26-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>				22b. DATE THEREOF <b>1-27-61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>WashDC</b>				22d. LOCATION (City, town, or country) (State) <b>Lititz Penna.</b>			
23. FUNERAL DIRECTOR <b>W.W. Chambers Funeral Home, 1400 Chapin St. NW</b>				24a. REC'D BY REGISTRAR <b>DATE JAN 30 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krens</b>							



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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00842

849

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>10</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Colesville Road Marilea Nursing Home</b>		d. STREET ADDRESS <b>1919 S. ...</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>D.</b> Last <b>Horton</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>?</b>
9. AGE (In years lost birthday) <b>100</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>XXXXXXXXXX none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>	
11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>- -</b>	
17. INFORMANT <b>Nursing Home records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 14, 1956</b> to <b>Jan 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 9, 1961</b> , and that death occurred <b>8:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John S. Rogers MD</b>		22b. DATE SIGNED <b>Jan 10 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>John S. Rogers</b>		22d. ADDRESS <b>1919 S. ...</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1/10/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W., Wash, D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 11 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

820

Name of Deceased		Age	
Sex		Race	
Date of Birth		Date of Death	
Place of Birth		Place of Death	
Cause of Death		Manner of Death	
Signature of Physician		Signature of Registrar	
Date		Place	

850

## CERTIFICATE OF DEATH

Reg. Dist. No.

00843

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>D.C.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL Rockville</i>		c. LENGTH OF STAY IN lb <i>4 Yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Waverley Sanitarium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i> First <i>S.</i> Middle <i>Hoskinson</i> Last		4. DATE OF DEATH Month <i>Jan</i> Day <i>8</i> Year <i>1961</i>	
5. SEX <i>Fe.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-3-1879</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>JAMES MONROE Farmer</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Dora BROWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Louis P. Allwine</i> Address <i>Waverley Sanit.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 332X DUE TO <i>Cerebral Thrombosis &amp; Hemiplegia</i> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO <i>Arteriosclerosis &amp; Hypertension</i> (b) <i>4 years</i> (c) <i>years?</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March</i> , 1954, to <i>Jan 8</i> , 1961, that I last saw the deceased alive on <i>Jan 7</i> , 1960, and that death occurred at <i>1:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Neil P. Campbell</i>		ADDRESS (Street, city or town, state) <i>Kennard Apt Wash DC</i> DATE SIGNED <i>1/8/61</i>	
PHYSICIAN'S NAME (Type) <i>Neil P. Campbell</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-11-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>OAK Hill</i>	22d. LOCATION (City, town, or county) (State) <i>WASHINGTON D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Lawler's Sons, WASH., D.C.</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JAN 10 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

850

NAME OF DECEASED  
JAMES MICHAEL BROWN  
AGE  
38  
SEX  
M  
DATE OF DEATH  
JAN 15 1950  
PLACE OF DEATH  
HOSPITAL  
CAUSE OF DEATH  
HEART DISEASE  
DISEASE OR INJURY  
IMMEDIATE PRECEDING  
DISEASE OR INJURY  
DISEASE OR INJURY  
DISEASE OR INJURY

SIGNATURE OF PHYSICIAN  
JAMES MICHAEL BROWN  
SIGNATURE OF WITNESSES  
JAMES MICHAEL BROWN

TESTAMENTS  
I, JAMES MICHAEL BROWN, do hereby certify that the above is a true and correct copy of the original certificate of death filed in my office on the 15th day of January, 1950.  
JAMES MICHAEL BROWN  
COUNTY CLERK



851

CERTIFICATE OF DEATH

Reg. Dist. No. 00844

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b <b>6 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home for the Aged, Inc.</b>				d. STREET ADDRESS <b>- -</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Edward</b> Last <b>Houck</b>				4. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 2, 1872</b>		9. AGE (In years lost birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Jackson Houck</b>				14. MOTHER'S MAIDEN NAME <b>Annie Elizabeth Lock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT <b>Asbury Home records</b>		Address <b>Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>17 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 15</b> , 19 <b>60</b> , to <b>Jan 2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Dec 30</b> , 19 <b>60</b> , and that death occurred at <b>9:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7720 Wisconsin Ave. Bethesda, Md.</b> DATE SIGNED <b>1-2-61</b>							
ACTUAL SIGNATURE <b>James W. Egan</b>				M.D. <b>7720 Wisconsin Ave. Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>James W. Egan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>1-5-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Church</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emmett C. Frazier</b>				ADDRESS <b>Gaithersburg, Md.</b>		24a. REC'D BY REGISTRAR <b>PAN 4</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Registration

Registration

Mr. R. H. R. R.

Mr. R. H. R. R.

Mr. R. H. R. R.

Robert Jackson for the Agent, Inc.

Robert

Robert

Robert

Nov. 2, 1915

Nov. 2, 1915

Anna Elizabeth Jackson

Anna Elizabeth Jackson

Anna Elizabeth Jackson

Anna Elizabeth Jackson

Anna Elizabeth Jackson

## CERTIFICATE OF DEATH

Reg. Dist. No.

60845

852

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wisconsin</u> b. COUNTY <u>Price</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phillips</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1016 Maple Avenue</u>		d. STREET ADDRESS <u>86X-3</u>	
3. NAME OF DECEASED (Type or print) <u>BARBARA ANN HROUDA</u> First Middle Last		4. DATE OF DEATH <u>January 2</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/83</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Czechoslovakia</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>----</u> INFORMANT <u>Agnes Triebull - Item # 1</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>arteriosclerotic Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 weeks</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12:15:60</u> , 19 <u>60</u> , to <u>1:2:61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1:2:61</u> , 19 <u>61</u> , and that death occurred at <u>6:15</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Phillips, Wisconsin</u> DATE SIGNED <u>1/3/61</u>			
ACTUAL SIGNATURE <u>William Frank</u> M.D.		PHYSICIAN'S NAME (Type) <u>William Frank</u> -544 W/ Montgomery Avenue, Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>1/3/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's</u>		22d. LOCATION (City, town, or county) (State) <u>Phillips, Wisconsin</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler-1331 E. Montg. Ave. Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 5 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

878

*[Faint, mostly illegible text and lines on a death certificate form. The form includes fields for name, date, time, and place of death, as well as a section for the cause of death. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]*

353

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN lb <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8706 GILBERT PLACE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAE</b> Middle <b>HILMA</b> Last <b>HUNTER</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>14</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/78</b>		9. AGE (In years lost birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>EMMA JOHNSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		INFORMANT Address <b>Mrs. Virginia G. MacWilliams, 8706 Gilbert Pl. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/22, 1960</b> to <b>1/13, 1961</b> that I lost saw the deceased olive on <b>1/13, 1961</b> and that death occurred at <b>8:59 AM</b> , from the causes and on the date stated above. BENNETT A. ROBIN, M.D. (Address, city, town, state) DATE SIGNED <b>317 UNIV. BLVD. EAST 1/16/61</b> <b>SILVER SPRING, MD.</b> <b>JU. 8-8700</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/17/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Giska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

823

MADE IN NEW YORK

NAME OF DECEASED  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
DATE OF DEATH  
PLACE OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF MINISTER OF THE GOSPEL  
SIGNATURE OF REGISTRAR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
854  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00847

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash - D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>478-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resman Hospital and Sanitarium</u>		d. STREET ADDRESS <u>627 Whitier St N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>Hutchinson</u> Last <u>Hutchinson</u>		4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26 - 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>81</u> Days <u>81</u> Hours <u>81</u> Min. <u>81</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WEST Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>WEST Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Undeclared</u>	
13. FATHER'S NAME <u>Jefferson Vandersdale</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Ziles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>not</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia,</u> <u>491X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2nd Hemiplosia</u> DUE TO <u>Arteriosclerosis Generalized</u> (c) <u>Undeclared</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterial Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 9</u> to <u>Jan 31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 31</u> , 19 <u>61</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>George L Ball</u>		22b. DATE SIGNED <u>Jan 31, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>George L Ball</u>		22d. ADDRESS <u>10620 George Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>2/1/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanks</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 2 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

RECEIVED

252

111

1918

855  
CERTIFICATE OF DEATH

Reg. Dist. No.

60848

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>8600 Flower Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Hutchison</u> Last <u>Hutchison</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-61</u>	9. AGE (In years last birthday) yrs. <u>10</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Glenn - Hutchison</u>				14. MOTHER'S MAIDEN NAME <u>Dolores Byer Beeghly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>mother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Valgene M. Milstead</u>		M.D. <u>1110 Spring St., Silver Spring, Md</u> <u>1/31/61</u>					
PHYSICIAN'S NAME (Type) <u>Valgene M. Milstead, M. D.</u>		<u>1110 Spring St., Silver Spring, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>1-31-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Hare, M. D. Washington San. &amp; Hosp.</u>				24a. REC'D BY REGISTRAR DATE <u>EB 2 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

356

00849

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>12 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1 Silver Spring</u>		d. STREET ADDRESS <u>1811 Patton Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>811 Patton Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Ishur</u> Last <u>Ishur</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-21-1891</u>	
9. AGE (in years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>roofing</u>		11. BIRTHPLACE (State or foreign country) <u>Russian</u>	
13. FATHER'S NAME <u>Kalman Ishur</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE</u> <u>Ishur</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>099-01-1335</u>		17. INFORMANT <u>Rose Ishur</u> Address <u>Ishur 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-6-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-8-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH</u>		22d. LOCATION (City, town, or country) (State) <u>VA.</u>	
23. FUNERAL DIRECTOR <u>B. DANZANSKY + SONS - 3501 - 14th ST. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Knecht</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH  
STATE HEALTH BOARD  
BUREAU OF VITAL RECORDS  
BOSTON, MASS.  
JAN 10 1910

FOR STATE  
HEALTH BOARD

256

W. W. W.

1910-1-10

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VR A15 (4)  
15M 9/59

00850

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>6 days 13hrs. 45min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>09 Gaithersburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>302 Frederick Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ray</b>		First <b>(NMN)</b>		Middle <b>Jefferies</b>		Last <b>January 29 19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 26, 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired RR. Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Evan Moore Jefferies</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Crossland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Transverse Colon</b> <b>153.1</b> DUE TO <b>Metastasis to liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Marked emphysema of lungs</b> DUE TO (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 19 1960</b> to <b>Jan. 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan. 28, 1961</b> , and that death occurred at <b>2</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Jack Schumacher</b>				22b. DATE SIGNED <b>1-29-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Jack Schumacher, M.D.</b>	
22d. ADDRESS <b>Gaithersburg, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-1-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		23d. LOCATION (City, town, or county) (State) <b>Uniontown Pa</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
858  
CERTIFICATE OF DEATH

60851

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>119 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Anthony</b> Last <b>Jewby</b>		4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 6, 1901</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technical Writer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William C. Jewby</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Bincowe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>226-56-3926</b>	
17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia and Septicemia</b> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple Myeloma</b> DUE TO (c) <b>8 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

2  
MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>September 29, 1960</b> to <b>January 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>January 26, 1961</b> , and that death occurred at <b>7:20 a.m.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Vincent H. Bono Jr.</b>		22b. DATE SIGNED <b>1/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Vincent H. Bono, Jr., MD</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/30/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Fa, Fairfax, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Douglas M. Rindoff</b>		25a. REC'D BY REGISTRAR <b>3245 Wilson Blvd.</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>
		DATE <b>JAN 30 '61</b>	

Bureau of Prisons, Federal Penitentiary, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00852

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>13</u> days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>7308 Alaska Ave. N.W.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jeanette</u> Middle <u>Sigmund</u> Last <u>Kaufman</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/78</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Sigmund</u>	
14. MOTHER'S MAIDEN NAME <u>Adeline Newmyer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Sydney C. Kaufman</u> <u>7308 Alaska Ave. NW</u> <u>Wash. DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Pneumonia - Left Lung -</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>3 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lung Tumor. Left lung -</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> <u>1961</u> to <u>1/21</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>1/21</u> <u>1961</u> , and that death occurred at <u>11:20</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John S. Ball</u>		22b. DATE SIGNED <u>1/22/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Bell</u>		22d. ADDRESS <u>7936 Georgetown Rd. Bethesda 14 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation 1/23/1961</u>		23b. DATE THEREOF <u>1/23/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Pauler's Sons Wash. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>		25c. DATE <u>JAN 24 '61</u>	

STATE OF TEXAS  
DEPARTMENT OF DEATHS

Signature

James E. ...

John ...



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
00853									
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 19 TAKOMA PARK				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8313 GARLAND AVE. Apt. #3					d. STREET ADDRESS 1 8313 GARLAND AVE.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) JOHN LAWRENCE KEARNEY, SR. BXX					4. DATE OF DEATH JAN. 26 1961				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/20/89		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skip Tracer(self-employed)		10b. KIND OF BUSINESS OR INDUSTRY Commercial Accounts		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES P. KEARNEY					14. MOTHER'S MAIDEN NAME EVA BEHRENS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 071-01-1541-A				
17. INFORMANT Mr. John L. Kearney, Jr., 7104 Annapolis Rd. Landover Hills, Maryland					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 Condition, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) FRANK J. BROSCHART					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED 1/27/61									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/30/61		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or country) (State) WASHINGTON, D.C.			
23. FUNERAL DIRECTOR ADDRESS WARNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond A. Ziska					24a. REC'D BY REGISTRAR DATE FEB 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

THE STATE  
HEALTH DEPT.

(1)

JAMES J. KERNAN

1901-1902

NEW BRIDGE

BRIDGE CO., N.J.

JOHN I. KERNAN, JR., 1001-1902

BRIDGE CO., N.J.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
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361

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

66854

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>52</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry</b> First <b>Leon</b> Middle <b>Kellock</b> Last		4. DATE OF DEATH <b>January</b> Month <b>21</b> Day <b>1961</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 17, 1877</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Kellock</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Simpson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>209-09-1199</b>	
17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>593x</b> IMMEDIATE CAUSE (a) <b>Cardiac standstill</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acidosis</b> DUE TO (c) <b>acute renal failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immed</b> <b>4 weeks</b> <b>4 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 30 1960</b> , to <b>January 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>January 21, 1961</b> , and that death occurred at <b>12:05 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. W. Bains</b>		22b. DATE SIGNED <b>1/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JERRY W. BAINS M.D.</b>		22d. ADDRESS <b>The Clinical Center National Institutes Of Health Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-25-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SOUTH FORK CEM</b>		23d. LOCATION (City, town, or county) (State) <b>SOUTH FORK PA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles O. Remond South Fork Pa</b>		25. REC'D BY REGISTRAR <b>JAN 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1100

1-22-61 South Park Inn South Fork

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00855

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>8 hours</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges Co.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chillum 1650-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium + Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <b>January</b>		Day <b>4</b>		Year <b>1961</b>			
3. NAME OF DECEASED (Type or print) <b>Patrick Kevin Kelly</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 5, 1896</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinist</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>					
13. FATHER'S NAME <b>John Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Julia O'Donnell</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>6hact</b>		17. INFORMANT <b>WASHington San &amp; Hosp.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>812X CEREBRAL HEMORRHAGE</b> DUE TO (b) <b>PULMONARY HEMORRHAGE</b> DUE TO (c) <b>STRUCK BY AUTOMOBILE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6-8 HRS.</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE FRACTURES OF LOWER EXTREMITIES</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Refused struck by hit + run auto. (pedestrian)</b>		20c. TIME OF INJURY Month, Day, Year <b>9:25 p.m. 1-3 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>highway</b>		20f. (City or town) (County) (State) <b>Green Meadows P.O. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <b>Frank J. Broschaw</b> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1-4-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-7-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or country) (State) <b>Wash. DC</b>		23. FUNERAL DIRECTOR <b>Horton Funeral Home</b>		ADDRESS <b>3831 5th St. N.W. Wash. D.C.</b>	
24a. REC'D BY REGISTRAR <b>Wash. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Wash. D.C.</b>		24c. DATE <b>JAN 10 1961</b>		24d. TIME <b>8:00</b>					

MEDICAL CERTIFICATION



*[Faint handwritten notes at the bottom of the page]*

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

863

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00856

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		d. STREET ADDRESS <u>11109 DEVERE DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CELIA</u> Middle <u>HEROES</u> Last <u>HEROES</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1896</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES TAISHOFF</u>		14. MOTHER'S MAIDEN NAME <u>EDITH FRIEDLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-12-3785</u>	
17. INFORMANT <u>EDITH HOROWITZ</u> Address <u>1109 DEVERE DR S. SPG. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 422.1 DUE TO <u>Arteriosclerotic Cerebrovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 14, 1961</u> to <u>January 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>19 January 1961</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Boris Rabkin</u>		22b. DATE SIGNED <u>Jan 25, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		22d. ADDRESS <u>1019 University Blvd East Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/26/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Healey Funeral Home</u> ADDRESS <u>4717-9th Ave</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 27 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Carling &amp; House</u>	

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Signature of physician

6. Signature of registrar

7. Signature of witness

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

864  
CERTIFICATE OF DEATH

Reg. Dist. No.

60857

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC</u> b. COUNTY <u>4-2-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ALTHEA WOODLAND HOME</u>				d. STREET ADDRESS <u>5012 Arkansas Ave NW</u>			
3. NAME OF DECEASED (Type or print) First <u>EMILIE</u> Middle <u>S.</u> Last <u>KESSLER</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 27, 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
13. FATHER'S NAME <u>CHRIS F. FENDNER</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA EBERTS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>EMMA KESSLER 5012 Arkansas Ave</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential hypertension moderate</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>60</u> , to <u>Jan. 6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan. 5</u> , 19 <u>61</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5600 16th Ave Wash DC</u> DATE SIGNED <u>1/7/61</u>							
ACTUAL SIGNATURE <u>Samuel M Bageant</u>				M.D. <u>5600 16th Ave Wash DC</u>			
PHYSICIAN'S NAME (Type) <u>Samuel M. Bageant, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-10-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home 4812 G St Annapolis</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Cathleen E. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John T. Miller</i></p>		<p>2. Date of death: <i>April 15, 1922</i></p>	
<p>3. Place of death: <i>Home</i></p>		<p>4. Age: <i>65</i></p>	
<p>5. Sex: <i>Male</i></p>		<p>6. Race: <i>White</i></p>	
<p>7. Occupation: <i>Teacher</i></p>		<p>8. Cause of death: <i>Heart failure</i></p>	
<p>9. Duration of illness: <i>2 weeks</i></p>		<p>10. Medical history: <i>None</i></p>	
<p>11. Name of physician: <i>Dr. J. H. Smith</i></p>		<p>12. Name of funeral home: <i>None</i></p>	
<p>13. Name of next of kin: <i>John T. Miller</i></p>		<p>14. Name of informant: <i>John T. Miller</i></p>	
<p>15. Address: <i>123 Main St.</i></p>		<p>16. City: <i>Baltimore</i></p>	
<p>17. State: <i>Md.</i></p>		<p>18. County: <i>Harford</i></p>	
<p>19. Date of burial: <i>April 17, 1922</i></p>		<p>20. Name of cemetery: <i>None</i></p>	
<p>21. Name of minister: <i>None</i></p>		<p>22. Name of sexton: <i>None</i></p>	
<p>23. Name of undertaker: <i>None</i></p>		<p>24. Name of embalmer: <i>None</i></p>	
<p>25. Name of coroner: <i>None</i></p>		<p>26. Name of registrar: <i>None</i></p>	
<p>27. Name of health officer: <i>None</i></p>		<p>28. Name of medical examiner: <i>None</i></p>	
<p>29. Name of pathologist: <i>None</i></p>		<p>30. Name of anatomist: <i>None</i></p>	
<p>31. Name of surgeon: <i>None</i></p>		<p>32. Name of dentist: <i>None</i></p>	
<p>33. Name of pharmacist: <i>None</i></p>		<p>34. Name of druggist: <i>None</i></p>	
<p>35. Name of optician: <i>None</i></p>		<p>36. Name of oculist: <i>None</i></p>	
<p>37. Name of physician: <i>None</i></p>		<p>38. Name of surgeon: <i>None</i></p>	
<p>39. Name of dentist: <i>None</i></p>		<p>40. Name of pharmacist: <i>None</i></p>	
<p>41. Name of druggist: <i>None</i></p>		<p>42. Name of optician: <i>None</i></p>	
<p>43. Name of oculist: <i>None</i></p>		<p>44. Name of physician: <i>None</i></p>	
<p>45. Name of surgeon: <i>None</i></p>		<p>46. Name of dentist: <i>None</i></p>	
<p>47. Name of pharmacist: <i>None</i></p>		<p>48. Name of druggist: <i>None</i></p>	
<p>49. Name of optician: <i>None</i></p>		<p>50. Name of oculist: <i>None</i></p>	
<p>51. Name of physician: <i>None</i></p>		<p>52. Name of surgeon: <i>None</i></p>	
<p>53. Name of dentist: <i>None</i></p>		<p>54. Name of pharmacist: <i>None</i></p>	
<p>55. Name of druggist: <i>None</i></p>		<p>56. Name of optician: <i>None</i></p>	
<p>57. Name of oculist: <i>None</i></p>		<p>58. Name of physician: <i>None</i></p>	
<p>59. Name of surgeon: <i>None</i></p>		<p>60. Name of dentist: <i>None</i></p>	
<p>61. Name of pharmacist: <i>None</i></p>		<p>62. Name of druggist: <i>None</i></p>	
<p>63. Name of optician: <i>None</i></p>		<p>64. Name of oculist: <i>None</i></p>	
<p>65. Name of physician: <i>None</i></p>		<p>66. Name of surgeon: <i>None</i></p>	
<p>67. Name of dentist: <i>None</i></p>		<p>68. Name of pharmacist: <i>None</i></p>	
<p>69. Name of druggist: <i>None</i></p>		<p>70. Name of optician: <i>None</i></p>	
<p>71. Name of oculist: <i>None</i></p>		<p>72. Name of physician: <i>None</i></p>	
<p>73. Name of surgeon: <i>None</i></p>		<p>74. Name of dentist: <i>None</i></p>	
<p>75. Name of pharmacist: <i>None</i></p>		<p>76. Name of druggist: <i>None</i></p>	
<p>77. Name of optician: <i>None</i></p>		<p>78. Name of oculist: <i>None</i></p>	
<p>79. Name of physician: <i>None</i></p>		<p>80. Name of surgeon: <i>None</i></p>	
<p>81. Name of dentist: <i>None</i></p>		<p>82. Name of pharmacist: <i>None</i></p>	
<p>83. Name of druggist: <i>None</i></p>		<p>84. Name of optician: <i>None</i></p>	
<p>85. Name of oculist: <i>None</i></p>		<p>86. Name of physician: <i>None</i></p>	
<p>87. Name of surgeon: <i>None</i></p>		<p>88. Name of dentist: <i>None</i></p>	
<p>89. Name of pharmacist: <i>None</i></p>		<p>90. Name of druggist: <i>None</i></p>	
<p>91. Name of optician: <i>None</i></p>		<p>92. Name of oculist: <i>None</i></p>	
<p>93. Name of physician: <i>None</i></p>		<p>94. Name of surgeon: <i>None</i></p>	
<p>95. Name of dentist: <i>None</i></p>		<p>96. Name of pharmacist: <i>None</i></p>	
<p>97. Name of druggist: <i>None</i></p>		<p>98. Name of optician: <i>None</i></p>	
<p>99. Name of oculist: <i>None</i></p>		<p>100. Name of physician: <i>None</i></p>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

865

C0858

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>59 Bethesda</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>17700 - Old Chester Rd.</i>			
3. NAME OF DECEASED (Type or print) First <i>BESS</i> Middle <i>K</i> Last <i>KICKLIGHTER</i>				4. DATE OF DEATH Month <i>JAN</i> Day <i>29</i> Year <i>1961</i>			
5. SEX <i>7</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 6, 1885</i>		9. AGE (In years last birthday) <i>75</i> yrs.	IF UNDER 1 YEAR Months <i>8</i> Days <i>23</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerical</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Veterans Bureau</i>		11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Alfred S. Kimball</i>				14. MOTHER'S MAIDEN NAME <i>Julia Reynolds</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Joe E. Kimball</i> Address <i>2700 Old Chester Rd. Bethesda, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.1 Congestive heart failure and myocarditis</i> DUE TO (b) <i></i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>this hospital</del> attended the deceased from <i>Apr. 1949</i> to <i>29 Jan. 1961</i> , that (I) <del>we</del> last saw the deceased alive on <i>28 Jan. 1961</i> , and that death occurred at <i>8 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Herbert Martyn Jr</i>				22b. ADDRESS <i>5029 Bethesda Ave.</i>			
22c. PHYSICIAN'S NAME (Type) <i>HERBERT MARTYN JR</i>				22d. ADDRESS <i>5029 Bethesda Ave.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/2/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat. Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Arlington Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				25a. REC'D BY REGISTRAR <i>FEB 2 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	

MEDICAL CERTIFICATION

may be retained by the hospital or attending physician.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH - 880 COMMERCIAL STREET - 02110



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/59

1  
MONTGOMERY  
070  
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2  
1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
366  
CERTIFICATE OF DEATH

00859

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>29 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp</u>				d. STREET ADDRESS <u>3716 Valley Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Adelaide Kathryn (1st) Kiebach</u>				4. DATE OF DEATH Month Day Year <u>Jan. 11 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1917</u>	
9. AGE (In years lost birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City of Alexandria</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>William Boucher Hacker</u>				14. MOTHER'S MAIDEN NAME <u>Florence Merkel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma of the ovary</u> 175.0 DUE TO (b) <u>ovary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/12/1960</u> to <u>1/11/1961</u> , that (I) <u>lost</u> saw the deceased alive on <u>1/11</u> 1961, and that death occurred at <u>8:11</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ronald E. Kiebach</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Emory-Wheatley F. Home</u>	
22d. ADDRESS <u>1110 Spring St Silver Spring Md.</u>				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 1-16-61</u>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	
23d. LOCATION (City, town, or county) (State) <u>ARLINGTON CO. VA.</u>				23e. DATE <u>JAN 16 '61</u>		23f. ADDRESS <u>U.S. VA.</u>	

CERTIFICATE OF DEATH

306

ARRINGTON NATIONAL ARRINGTON 1925

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

867

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00860

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>Lewis</b> Last <b>Kilby</b>				4. DATE OF DEATH Month <b>1</b> Day <b>14</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1891</b>	9. AGE (In years lost birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b> Hours <b>14</b> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Edgar Carter Kilby</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>No</b>				16. SOCIAL SECURITY NO. <b>220-26-6735</b>		17. INFORMANT <b>Warner T. Kilby (son)</b> Address <b>Rt. 1 Germantown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Thrombosis, right coronary art.</b> (c) <b>Arteriosclerosis, coronary art.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Abdominal aortic aneurysm with thrombosis of hepatic artery</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 2</b> 19 <b>61</b> to <b>Jan 14</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Jan 13</b> 19 <b>61</b> , and that death occurred at <b>5</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Leonard Peterson</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Leonard T. Peterson</b>	
22d. ADDRESS <b>8215 Wisconsin - Bethesda Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-16-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>600 Farmer, Fairhurstburg Md</b>				25. REC'D BY REGISTRAR DATE <b>JAN 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>	

CP

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

307

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *Jan 1, 1900*  
5. Place of birth: *New York City*  
6. Date of death: *Dec 15, 1945*  
7. Place of death: *New York City*  
8. Cause of death: *Heart Disease*  
9. Duration of illness: *Several months*  
10. Name of physician: *Dr. J. Smith*  
11. Name of funeral home: *John Doe & Co.*  
12. Name of informant: *John Doe*  
13. Address of informant: *123 Main St., New York City*  
14. Signature of informant: *[Signature]*  
15. Date of completion: *Dec 16, 1945*

## CERTIFICATE OF DEATH

Reg. Dist. No.

868

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Purdum</u>				c. LENGTH OF STAY IN 1b <u>8 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD # 1, Monrovia</u>				d. STREET ADDRESS <u>RFD # 1, Monrovia</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Bonnie</u> Middle <u>Jean</u> Last <u>King</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27, 1952</u>	
9. AGE (In years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Purdum, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Earl V. King</u>				14. MOTHER'S MAIDEN NAME <u>Mildred F. Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>			
INFORMANT <u>Earl V. King, Item 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>751X Congenital hydrocephalus</u> DUE TO <u>Congenital meningococci</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 years</u> DUE TO <u>8 years</u> (c) <u>8 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>11 20</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Purdum, Md.</u>				20g. (County) <u>Damascus, Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>6/27</u> , 19 <u>52</u> to <u>1/3</u> , 19 <u>61</u> that I last saw the deceased alive on <u>11/20</u> , 19 <u>60</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kerr</u>				ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>			
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>				DATE SIGNED <u>1/3/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 5, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		22d. LOCATION (City, town, or county) (State) <u>Purdum, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olum L. Mohamath</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

303

County of Suffolk

City of Boston

Age 6 years

Sex - Female

Color - White

1

Date of Death - June 27, 1922

Place of Death - Home

Cause of Death - Infantile Spasms

Direct Cause of Death - Same

Signature of Physician

Witness

Signature

Signature

Signature



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

869

CERTIFICATE OF DEATH

Reg. Dist. No.

00862

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>1 Year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Brooke Grove Foundation</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Sybell</b> Last <b>King</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>28</b> Year <b>61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-2-80</b>
9. AGE (In years lost birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas Ward</b>		14. MOTHER'S MAIDEN NAME <b>Ida Warfield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not known) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Glenwood D. King</b>		Address <b>Damascus, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>11:27</b> p. m. <b>19 61</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/15</b> , 19 <b>45</b> to <b>1/28</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1/27</b> , 19 <b>61</b> , and that death occurred at <b>2:25</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James P. Kerr</b>		ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>		DATE SIGNED <b>1/28/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-30-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Damascus</b>	22d. LOCATION (City, town, or county) (State) <b>Damascus, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis D. Barber</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '61</b>	
ADDRESS <b>Laytonsville. Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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**References**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

870

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00863

1. PLACE OF DEATH a. COUNTY: <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE: <u>Maryland</u> b. COUNTY: <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>37 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>701 Ritchie Avenue</u>		d. STREET ADDRESS <u>1701 Ritchie Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>ELIZABETH</u> Last <u>KNIGHT</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/23</u>
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Whitney Walter</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-20-1251</u>	
17. INFORMANT <u>Whitney Walter</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration &amp; Malnutrition</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of Ovary &amp; Metastases</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 10, 1960</u> to <u>January 1, 1961</u> , that (I) <u>last</u> saw the deceased alive on <u>12/30</u> 19 <u>60</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Armon A. Cairo</u>		22b. DATE SIGNED <u>1/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Armon A. Cairo</u>		22d. ADDRESS <u>Georgetown Univ. Hosp., Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 4, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>P. Geo. Co. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 4 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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## Reg. Dist. No.

871

MEDICAL CERTIFICATIONVS A1S (4)  
1SM 9/SB

may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10 - 1  
A15 (4)  
9/SB

CERTIFICATE OF DEATH

871

County of Montgomery  
State of Alabama  
I, John H. Smith, Registrar of the County of Montgomery, State of Alabama, do hereby certify that

on the 12th day of April, 1921, at Montgomery, Alabama, died Carl B. Smith, of the County of Montgomery, State of Alabama, who was born on the 15th day of March, 1888, at Montgomery, Alabama.

He was a white male, of the age of 32 years, single, and a native born citizen of the State of Alabama. He was employed as a clerk in the Post Office at Montgomery, Alabama.

He was afflicted with typhoid fever, which began on the 10th day of April, 1921, and he died of the same on the 12th day of April, 1921. The attending physician was Dr. J. H. Smith.

The death was caused by typhoid fever, which was contracted at Montgomery, Alabama. The deceased was buried on the 13th day of April, 1921, at Montgomery, Alabama, in the Central Cemetery.

Witness my hand and the seal of the County of Montgomery, State of Alabama, this 13th day of April, 1921.  
John H. Smith, Registrar of the County of Montgomery, State of Alabama.

Subscribed and sworn to before me this 13th day of April, 1921.  
Notary Public for the State of Alabama.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
15M 9/59

872  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

60865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmaa Hospital and Sanitarium</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mary Ellen Landgraf</u>			4. DATE OF DEATH <u>Jan 23 1961</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>WHITE</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Jan 30 - 1872</u>		
9. AGE (In years lost birthday) <u>88</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		
11. BIRTHPLACE (State or foreign country) <u>Germany</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Frank S. Stehle</u>			14. MOTHER'S MAIDEN NAME <u>Mary Martha Lenney</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>Mrs. Frank C. Maley, 105 Southbrook Lane</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1939</u> to <u>23 Jan 1961</u> that (I) (we) last saw the deceased alive on <u>23 Jan 1961</u> and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>William D. Aud</u>			22b. DATE SIGNED <u>1/23/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>			22d. ADDRESS <u>9006 Colesville Road, Silver Spring, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>1/25/61</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>			23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u>			25a. REC'D BY REGISTRAR <u>SILVER SPRING, MD.</u>		
25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			DATE <u>JAN 26 '61</u>		

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
OFFICE OF THE ASSISTANT ATTORNEY GENERAL  
DIVISION OF VITAL RECORDS  
CERTIFICATE OF DEATH

372

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

873

## CERTIFICATE OF DEATH

60866

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>8236 14th Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph</u> <u>Landman</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>1</u> <u>15</u> <u>1961</u> Month Day Year		<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Russia</u>			
<b>13. FATHER'S NAME</b> <u>Reuben Landman</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN MELAMID</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Amer.</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Hospital Records</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Pneumonia terminal</u> 526X } DUE TO <u>Bronchitis + chronic bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10-15 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>1) Atherosclerotic heart disease 2) Diabetes mellitus 3) Hypertension of heart</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>January 15, 1961</u> to <u>1-15-61</u> , that (I) (we) last saw the deceased alive on <u>1-15-61</u> , and that death occurred at <u>3:35</u> A.M. from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <u>Jason Geiger</u> M.D. <b>22b. DATE SIGNED</b> <u>1-15-61</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JASON GEIGER, M.D.</u>		<b>22d. ADDRESS</b> <u>1110 SPRING STREET SILVER SPRING, MD.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>1-16-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ONEVSHOLOM-TALMUD TORAH CEM. WASHINGTON. D.C.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Bernard Danzansky &amp; Sons - 3501-14th St NW</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 17 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>			

4458

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

874

00867

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>10 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>Rt. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ALICE</b> Middle <b>ELIZABETH</b> Last <b>LEE</b>				<b>4. DATE OF DEATH</b> Month <b>JANUARY</b> Day <b>18</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/10/92</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. AGE (In years last birthday) <b>68</b> yrs.		11. AGE (In years last birthday) <b>68</b> yrs.		12. AGE (In years last birthday) <b>68</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>BAKER SEDGWICK</b>				14. MOTHER'S MAIDEN NAME <b>LAURA POWELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. RUPTURED ANEURYSM, THORACIC AORTA</b> <b>451 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>2. HEMOTHORAX (6000 cc)</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>Jan 18</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Jan 18</b> , 19 <b>61</b> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard A. Yates M.D.</b>				22b. DATE SIGNED <b>1/18/61</b>		22c. PHYSICIAN'S NAME (Type) <b>RICHARD A. YATES, M. D.</b>	
22d. ADDRESS <b>OLNEY, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/22/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Pleasant Cemetery</b>		23d. LOCATION (City, town, or county) _____ (State) _____ <b>N orbeck, MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Surwden</b>				ADDRESS <b>Rockvillen, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 26 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
#

375

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00868

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>11 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6200 Valley Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>E.</b> Last <b>LEE</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>13,</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 10, 1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Fairfax, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Lee</b>				14. MOTHER'S MAIDEN NAME <b>Crump</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-03-4080</b>		17. INFORMANT <b>Wife Sara E. Lee</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Acute coronary thrombosis</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b> <b>3 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/17/60</b> to <b>1/13/61</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/12/61</b> , 19____, and that death occurred at <b>3:15 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert N. Coale</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-13-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>				22d. ADDRESS <b>4630 Montgomery Ave., Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-14-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 16 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Haines</b>			

1

CERTIFICATE OF DEATH

White Snow Mountain  
Cathedral

10/10/10

10/10/10

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00869

376

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>20 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>919 Gist Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Lucinda</i> Last <i>Leonard</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>3</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1877 April 6</i>
9. AGE (In years last birthday) <i>83</i>		10. IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>James L Green</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Daly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>none</i>	
17. INFORMANT <i>Daughter</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 44-2X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Heart Disease</i> DUE TO <i>Cardiac Hypertrophy</i> (c) <i>Senility</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>		<i>6 months</i>	
<i>1 yr</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 24, 1960</i> to <i>Jan 3, 1961</i> , that I last saw the deceased alive on <i>Jan 3, 1961</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip E. Jones</i> M.D.		ADDRESS (Street, city or town, state) <i>918 Clearworth Drive</i> DATE SIGNED <i>1/3/61</i>	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>		<i>Silver Spring Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/7/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>Jan 11 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		MARRIAGE <i>Married</i>		OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St, Baltimore, Md.</i>		DATE OF DEATH <i>Jan 15, 1925</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		SIGNATURE OF PHYSICIAN <i>J. Smith</i>		SIGNATURE OF REGISTRAR <i>A. Jones</i>		DATE OF REGISTRATION <i>Jan 16, 1925</i>		OFFICE OF REGISTRATION <i>Baltimore</i>											
FATHER'S NAME <i>John Doe</i>		MOTHER'S NAME <i>Jane Doe</i>		BIRTH DATE <i>Jan 1, 1880</i>		BIRTH PLACE <i>Baltimore, Md.</i>		EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>		POLITICAL PARTY <i>Democrat</i>		MILITARY SERVICE <i>None</i>		PREVIOUS ILLNESS <i>None</i>		TREATMENT <i>None</i>		LAST MEALS <i>Normal</i>		LAST SEEN ALIVE <i>Jan 14, 1925</i>		TIME OF DEATH <i>10:00 AM</i>		TEMPERATURE <i>Normal</i>		PULSE <i>Normal</i>		RESPIRATION <i>Normal</i>									
FATHER'S OCCUPATION <i>Teacher</i>		MOTHER'S OCCUPATION <i>Homemaker</i>		FATHER'S BIRTH DATE <i>Jan 1, 1850</i>		FATHER'S BIRTH PLACE <i>Baltimore, Md.</i>		MOTHER'S BIRTH DATE <i>Jan 1, 1855</i>		MOTHER'S BIRTH PLACE <i>Baltimore, Md.</i>		FATHER'S DEATH DATE <i>None</i>		FATHER'S DEATH PLACE <i>None</i>		MOTHER'S DEATH DATE <i>None</i>		MOTHER'S DEATH PLACE <i>None</i>		FATHER'S DEATH CAUSE <i>None</i>		FATHER'S DEATH MANNER <i>None</i>		MOTHER'S DEATH CAUSE <i>None</i>		MOTHER'S DEATH MANNER <i>None</i>		FATHER'S DEATH DATE <i>None</i>		FATHER'S DEATH PLACE <i>None</i>		FATHER'S DEATH CAUSE <i>None</i>		FATHER'S DEATH MANNER <i>None</i>					
FATHER'S DEATH DATE <i>None</i>		FATHER'S DEATH PLACE <i>None</i>		FATHER'S DEATH CAUSE <i>None</i>		FATHER'S DEATH MANNER <i>None</i>		MOTHER'S DEATH DATE <i>None</i>		MOTHER'S DEATH PLACE <i>None</i>		MOTHER'S DEATH CAUSE <i>None</i>		MOTHER'S DEATH MANNER <i>None</i>		FATHER'S DEATH DATE <i>None</i>		FATHER'S DEATH PLACE <i>None</i>		FATHER'S DEATH CAUSE <i>None</i>		FATHER'S DEATH MANNER <i>None</i>		MOTHER'S DEATH DATE <i>None</i>		MOTHER'S DEATH PLACE <i>None</i>		MOTHER'S DEATH CAUSE <i>None</i>		MOTHER'S DEATH MANNER <i>None</i>		FATHER'S DEATH DATE <i>None</i>		FATHER'S DEATH PLACE <i>None</i>		FATHER'S DEATH CAUSE <i>None</i>		FATHER'S DEATH MANNER <i>None</i>	
FATHER'S DEATH DATE <i>None</i>		FATHER'S DEATH PLACE <i>None</i>		FATHER'S DEATH CAUSE <i>None</i>		FATHER'S DEATH MANNER <i>None</i>		MOTHER'S DEATH DATE <i>None</i>		MOTHER'S DEATH PLACE <i>None</i>		MOTHER'S DEATH CAUSE <i>None</i>		MOTHER'S DEATH MANNER <i>None</i>		FATHER'S DEATH DATE <i>None</i>		FATHER'S DEATH PLACE <i>None</i>		FATHER'S DEATH CAUSE <i>None</i>		FATHER'S DEATH MANNER <i>None</i>		MOTHER'S DEATH DATE <i>None</i>		MOTHER'S DEATH PLACE <i>None</i>		MOTHER'S DEATH CAUSE <i>None</i>		MOTHER'S DEATH MANNER <i>None</i>		FATHER'S DEATH DATE <i>None</i>		FATHER'S DEATH PLACE <i>None</i>		FATHER'S DEATH CAUSE <i>None</i>		FATHER'S DEATH MANNER <i>None</i>	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A REGISTRAR OF DEATHS IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8219 Flower Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lewis</u>		First <u>Conrad</u> Middle <u>Linkins</u> Last <u>Linkins</u>		4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>11-26-1890</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>Frank Linkins</u>		14. MOTHER'S MAIDEN NAME <u>MacDonald</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1917-1919</u>		17. INFORMANT <u>Louise M. Linkins</u> Address <u>8219 Flower Ave. Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>					
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. ACTUAL SIGNATURE <u>Frank J. Broschert</u>		23. EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		24. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>  </u>			
25. DATE SIGNED <u>1-9-61</u>		26. DATE SIGNED <u>  </u>					
27a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		27b. DATE THEREOF <u>Jan 12, 1961</u>		27c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			
27d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>		28. FUNERAL DIRECTOR <u>Arthur Walters</u> Address <u>254 Carroll St NW D.C.</u>					
29. DATE BY REGISTRAR <u>JAN 11 '61</u>		30. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					



1  
JUN 21 1911  
M

Montgomery  
Farmers Bank  
Washington  
Lewis  
Male White  
Specialist  
Frank Perkins  
Yes 1911

Washington D.C. American  
11-2-1911  
Conrad Perkins  
2nd Floor  
D.A. Perkins  
Washington  
House of Perkins



878

# CERTIFICATE OF DEATH

Reg. Dist. No. 6687

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Gen Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>41</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>9632 Kensington Pkwy</u>	
3. NAME OF DECEASED (Type or print) <u>George F. List</u>		4. DATE OF DEATH <u>Jan 4 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 JAN 1869</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER (R.)</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN ELIZABETH REINSTEIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>567-22-2915A</u>	
17. INFORMANT <u>CDR H.M. KALSTAD,</u>		Address <u>KENSINGTON MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>12/16, 1960</u> , to <u>present</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/3, 1961</u> , and that death occurred at <u>9:25 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhau</u>		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAN</u>		DATE SIGNED <u>1/4/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/4/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JAN 6 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

(M)  
X

I

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
879 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
Items 15, 17 Film 280 2-2-61 et														
60872														
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>57 Bethesda</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>6005 Gloster Rd</i>					d. STREET ADDRESS <i>1 6005 Gloster Rd</i>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <i>Philip R. Lockwood</i>					4. DATE OF DEATH Month <i>Jan</i> Day <i>18</i> Year <i>1961</i>									
5. SEX <i>Male</i>					6. COLOR OR RACE <i>White</i>									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <i>6-9-46</i>									
9. AGE (In years last birthday) <i>14</i> yrs.					10. AGE (In years last birthday) <i>14</i> yrs.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Junior High Student</i>					10b. KIND OF BUSINESS OR INDUSTRY									
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>									
13. FATHER'S NAME <i>Ralph B. Lockwood</i>					14. MOTHER'S MAIDEN NAME <i>Florence Johnston</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>None</i>									
17. INFORMANT <i>Ralph B. Lockwood - Steu 2</i>					Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> 974X DUE TO <i>Hanging</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hanging</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i> sudden</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Found hanging by neck in basement of home</i>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>12:05</i> p.m. <i>1-18</i> 1961					20d. INJURY OCCURRED While <input type="checkbox"/> No While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>					20f. (City or town) (County) (State) <i>Bethesda Montg md</i>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Frank J. Broschert</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
					DATE SIGNED <i>1-18-61</i>									
					Address (Street, city, town, or country)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			22b. DATE THEREOF <i>1/21/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat. Cem.</i>			22d. LOCATION (City, town, or country) (State) <i>Arlington, Virginia</i>						
23. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>					24a. REC'D BY REGISTRAR <i>Bethesda, Maryland</i>					24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>				
					DATE <i>JAN 23 '61</i>									

DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
No. 123456789  
State of Maryland

FOR STATE  
RECORDING

On this day of the year 1901, I, the undersigned, Medical Examiner, do hereby certify that the within and foregoing is a true and correct copy of the original certificate of death filed in my office, and that the same is a true and correct copy of the original certificate of death filed in my office.

1

Florence Johnston

Ralph A. Johnston

None

No

Attest my hand and the seal of the Department of Health, this day of the year 1901.

Medical Examiner

Robert A. Ramseyer, Secretary, Maryland  
1/21/01  
Alington Not. Com. Virginia

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Item 18 Film 2-28-63											
MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
880 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00873											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>						c. LENGTH OF STAY IN 1b <u>DOA</u>					
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>						d. STREET ADDRESS <u>12920 Larkin Place</u>					
e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Patricia Ann Lokey</u>						4. DATE OF DEATH <u>1/26/61</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>12/22 1933</u>					
9. AGE (In years last birthday) <u>27</u> yrs.						10. IF UNDER 1 YEAR Months Days					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>Calif.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Stauffer</u>						14. MOTHER'S MAIDEN NAME <u>Eleanor Rees</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>Husband (Charles Lokey)</u>					
17. INFORMANT <u>Husband (Charles Lokey)</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> <u>Acute myocardial insufficiency</u> DUE TO (b) <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapsed while shoveling snow</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Collapsed while shoveling snow</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
DATE SIGNED <u>1-27-61</u>											
ACTUAL SIGNATURE <u>Frank J. Brorchart</u>											
EXAMINER'S NAME (Type) <u>Frank J. Brorchart</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>1/31/61</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>											
22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>											
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1331 E. Montgomery Avenue, Rockville, Md.</u>											
24a. REC'D BY REGISTRAR <u>JAN 30 '61</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

MEDICAL CERTIFICATION



280

12/22/1952

12/22/1952

John J. (Charles Jones)

John J. (Charles Jones)

Frank J. (Charles Jones)



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

3881  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00874

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>16 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>727 EASLEY STREET</u>				d. STREET ADDRESS <u>1 727 EASLEY STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WINIFRED</u> Middle <u>S.</u> Last <u>LYNCH</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>11</u> Year <u>19 61</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-67</u>		9. AGE (In years lost birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENNA.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM STUTHERS</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN Mc HALE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>MARY G. LYNCH SAME AS # 2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) arteriosclerosis (2) Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19 53</u> to <u>11 Jan 19 61</u> , that (I) (we) last saw the deceased alive on <u>10 Jan 19 61</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Aud</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>				22d. ADDRESS <u>9006 Colesville Rd. Silver Spring MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>				ADDRESS <u>WASH. D. C. 3821 14th. St. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 12 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATE OF TEXAS  
COUNTY OF DALLAS

1981

(M)

I, the undersigned, Clerk of the County of Dallas, State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

Witness my hand and the seal of said County at Dallas, Texas, this 1st day of January, 1981.

\_\_\_\_\_  
Clerk of the County of Dallas, State of Texas

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00875

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FALLAND</b>		c. LENGTH OF STAY IN 1b <b>11/27/60-1/23/61</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FALLAND NURSING HOME</b>		d. STREET ADDRESS <b>4106 GAITHER ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alvine</b>		First <b>F</b>		Middle <b>LYNHAM</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>NOV-16-1874</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>Charles Lynham</b>		14. MOTHER'S MAIDEN NAME <b>Debra O'Connell</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Lucy A Lynham</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the sigmoid</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1</b> 1960 to <b>Jan 27</b> 1961, that (I) (we) last saw the deceased alive on <b>1-21</b> 1961, and that death occurred on <b>1-23</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Leonard Hays</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-23-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leonard Hays</b>		22d. ADDRESS <b>Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 26, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 26 1961</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

883 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00876

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>1 1/2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4110 Fessenden St. N.W.</b> d. STREET ADDRESS <b>4110 Fessenden St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Florence P. Mac Donald</b>		4. DATE OF DEATH Month Day Year <b>Jan. 12 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2 1891</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		9b. AGE (in years last birthday) <b>69</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. D.C</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Gerald Piper</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Duetch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Daughter Mrs. Allen Minnix Jr. (Same as Item 2)</b>	
17. INFORMANT <b>Daughter Mrs. Allen Minnix Jr. (Same as Item 2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Subdural Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pontine Hemorrhage</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fell on floor at home</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on floor at home</b>		20c. TIME OF INJURY Month, Day, Year <b>7 A.M. 1-10-61</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Wash. D.C</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Brochart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1.12.61</b>	
Address (Street, city, town, or county) <b>5103 this side</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	
22b. DATE THEREOF <b>1/16/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cems.</b>	
22d. LOCATION (City, town, or country) (State) <b>Bladensburg RD. Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 18 '61</b>	
23. FUNERAL DIRECTOR <b>Chung Chase Funeral Home</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

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## CERTIFICATE OF DEATH

Reg. Dist. No.

60877

884

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GARRETT PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X GARRETT PARK (BETHESDA)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Georgetown Preparatory School</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>REV KELVIN T. MACKAVANAGH</b>		4. DATE OF DEATH <b>Jan / 5 / 19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20 1907</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Priest</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religious</b>	
11. BIRTHPLACE (State or foreign country) <b>Nova Scotia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S</b>	
13. FATHER'S NAME <b>Thomas MacKavanagh</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Religious House Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Coronary atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>2 hrs.</b> <b>Indeterminate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/1/1960</b> to <b>1/5/1961</b> , that I last saw the deceased alive on <b>1/5/1961</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Proctorville, Md</b> DATE SIGNED <b>1/5/61</b>			
ACTUAL SIGNATURE <b>Stephen E. Jones</b> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-9-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Georgetown College Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. Don. DeVol</b> ADDRESS <b>2224 Wisc Ave</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 17 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: JOHN WHITE

2. SEX: MALE

3. AGE: 45

4. DATE OF BIRTH: 1910-01-15

5. PLACE OF BIRTH: NEW YORK

6. OCCUPATION: LABORER

7. CAUSE OF DEATH: HEART DISEASE

8. DATE OF DEATH: 1955-03-10

9. PLACE OF DEATH: HOME

10. SIGNATURE OF PHYSICIAN: [Signature]

11. SIGNATURE OF REGISTRAR: [Signature]

12. SIGNATURE OF WITNESS: [Signature]

13. SIGNATURE OF DECEASED: [Signature]

14. SIGNATURE OF NEXT OF KIN: [Signature]

15. SIGNATURE OF CLERK: [Signature]

16. SIGNATURE OF JUDGE: [Signature]

17. SIGNATURE OF SHERIFF: [Signature]

18. SIGNATURE OF CORONER: [Signature]

19. SIGNATURE OF DISTRICT ATTORNEY: [Signature]

20. SIGNATURE OF COUNTY CLERK: [Signature]

21. SIGNATURE OF CITY CLERK: [Signature]

22. SIGNATURE OF TOWNSHIP CLERK: [Signature]

23. SIGNATURE OF VILLAGE CLERK: [Signature]

24. SIGNATURE OF POST OFFICE CLERK: [Signature]

25. SIGNATURE OF SCHOOL CLERK: [Signature]

26. SIGNATURE OF CHURCH CLERK: [Signature]

27. SIGNATURE OF SYNAGOGUE CLERK: [Signature]

28. SIGNATURE OF MOSQUE CLERK: [Signature]

29. SIGNATURE OF TEMPLE CLERK: [Signature]

30. SIGNATURE OF OTHER CLERK: [Signature]

1. This certificate is to be filled out by the physician or other person who has attended the deceased, or by the registrar, or by the witness, or by the deceased, or by the next of kin, or by the clerk, or by the judge, or by the sheriff, or by the coroner, or by the district attorney, or by the county clerk, or by the city clerk, or by the township clerk, or by the village clerk, or by the post office clerk, or by the school clerk, or by the church clerk, or by the synagogue clerk, or by the mosque clerk, or by the temple clerk, or by other clerk.

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00878

885

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>10 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2206 Hildarose Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>A.</b> Last <b>Maresch</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/11/1899</b>	
9. AGE (In years lost birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Duluth, Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Frederick C. Ehling</b>				14. MOTHER'S MAIDEN NAME <b>Cora Mae Shattuck</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Anthony Maresch</b> Address <b>S.S., Md.</b> <b>2206 Hildarose Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous Pleural Effusion</b> DUE TO <b>Carcinoma of Right Breast &amp; Metastasis To Lung &amp; Skin</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>170X</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>4 week</b> <b>5 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 9</b> , 19 <b>61</b> , to <b>Jan. 22</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>Jan 21</b> , 19 <b>61</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William Frank</b>				22b. ADDRESS <b>54 W. MONTGOMERY AVE ROCKVILLE, MD.</b>		22c. DATE SIGNED <b>Jan. 22, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM FRANK, M.D.</b>				22d. ADDRESS <b>54 W. MONTGOMERY AVE ROCKVILLE, MD.</b>		22e. DATE SIGNED <b>Jan. 22, 1961</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/25/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				25a. REC'D BY REGISTRAR <b>JAN 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

I

CERTIFICATE OF DEATH

1982

1. Name of Deceased: [Illegible]  
2. Date of Death: [Illegible]  
3. Place of Death: [Illegible]  
4. Cause of Death: [Illegible]  
5. Age at Death: [Illegible]  
6. Sex: [Illegible]  
7. Race: [Illegible]  
8. Marital Status: [Illegible]  
9. Occupation: [Illegible]  
10. Signature of Doctor: [Illegible]  
11. Signature of Registrar: [Illegible]  
12. Date of Registration: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>												c. LENGTH OF STAY IN 1b <u>22</u> <u>Silver Spring</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>												d. STREET ADDRESS <u>571 University Blvd.</u>											
3. NAME OF DECEASED (Type or print) <u>Lurman Wallace Marsh</u>												4. DATE OF DEATH <u>Jan. 22 1961</u>											
5. SEX <u>Male</u>												6. COLOR OR RACE <u>Cauc.</u>											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH <u>2-27-70</u>											
9. AGE (In years last birthday) <u>90</u> yrs.												10. IF UNDER 1 YEAR Months Days											
11. IF UNDER 24 HRS. Hours Min.												12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Builder</u>												10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>											
11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>												12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Charles Marsh</u>												14. MOTHER'S MAIDEN NAME <u>Abbie Greene</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>												16. SOCIAL SECURITY NO. <u>Mr. Burton W. Marsh - Washington, D.C.</u>											
17. INFORMANT <u>Son. 3126 Rittenhouse St.,</u>												18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>												INTERVAL BETWEEN ONSET AND DEATH											
331X } DUE TO												Cerebral arteriosclerosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>Jan 13, 1961</u> <u>8:20</u> p.m.												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 13, 1961</u> , to <u>Jan 22, 1961</u> ; that (I) (we) last saw the deceased alive on <u>Jan 22, 1961</u> , and that death occurred at <u>8:20</u> p.m., from the causes and on the date stated above.												22a. SIGNATURE <u>Eino Magi</u> M.D.											
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>												22d. ADDRESS <u>918 Univ. Blvd. E., Silver Spring, Md.</u>											
22b. DATE SIGNED <u>1/22/61</u>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>JAN 1961</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>HOPE CEMETERY</u>												23d. LOCATION (City, town or county) (State) <u>Worcester, Worcester Co., Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Thomas</u>												25a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u>											
ADDRESS <u>254 Canal St NW, D.C.</u>												25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>											
DATE <u>JAN 25 '61</u>																							

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

887

## CERTIFICATE OF DEATH

Reg. Dist. No. 00880

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darsonville (RURAL)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darsonville (Rural)</u>	
c. LENGTH OF STAY IN 1b <u>1 yr</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW MASON</u>		4. DATE OF DEATH Month Day Year <u>Jan. 20 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cobred</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Hebron</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left hemiplegia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>12 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from 15 Nov. 1958 to Jan 20, 1961, that I last saw the deceased alive on Jan 2, 1961, and that death occurred at 2 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE John Lawrence M.D. ADDRESS (Street, city or town, state) Darsonville DATE SIGNED 1/20/61

PHYSICIAN'S NAME (Type) P.O. BOYD, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/26/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul.</u>	22d. LOCATION (City, town, or county) (State) <u>Sugarland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swartz</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Cuthbert S. Lewis</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Place of death: \_\_\_\_\_  
8. Cause of death: \_\_\_\_\_  
9. Signature of physician: \_\_\_\_\_  
10. Signature of registrar: \_\_\_\_\_  
11. Date of registration: \_\_\_\_\_

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

388

00881

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>47</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5308 Huntington Parkway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>L.</b> Last <b>MAST</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>3,</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 2, 1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Church Organist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Henry</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Lane</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Son</b> <b>A.L. Thomas</b>		Address <b>18 Nod Rd., Ridgefield, Conn.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> DUE TO <b>Viral Gastroenteritis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>Possible myocardial infarction</b> <b>1 hour</b> <b>atherosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>myocardial infarction 2 years ago</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 2, 1961</b> to <b>Jan 2, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Jan 2, 1961</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward W. Youngblood</b>				22b. DATE <b>Jan 3, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Edward W. Youngblood</b>	
22d. ADDRESS <b>8606 Ewing Drive, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-5-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				25a. REC'D BY REGISTRAR <b>JAN 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

682

Montgomery

Bedford

2308 Huntington Parkway

Female White

Unemployed

White Male

Montgomery

Bedford

2308 Huntington Parkway

Female White

Unemployed

White Male

Very interesting

possibly unexplained

unexplained information

June 21

Thank you very much

Edward J. Youngblood

200 S. Main St.,

Montgomery, Alabama

Enclosed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

889

## CERTIFICATE OF DEATH

Reg. Dist. No.

60882

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>109 Park St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Donald</u>		First <u>R.</u> Middle <u>Mathers</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1943</u>	9. AGE (In years lost birthday) <u>17</u> yrs.	IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min.	IF UNDER 24 HRS. Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Mathers</u>				14. MOTHER'S MAIDEN NAME <u>Louise Hedges</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-38-377B</u>		INFORMANT <u>William H. Mathers</u> Address <u>109 Park St. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> <u>Carotomatosis Pulmonary</u> DUE TO (b) <u>Sarcoma of Left Femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>18 mos</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 27, 1959</u> to <u>Jan 4, 1961</u> , that I last saw the deceased alive on <u>Jan 4, 1961</u> , and that death occurred at <u>4:15 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.S. Murphy</u>				DATE SIGNED <u>Jan 4, 1961</u>			
PHYSICIAN'S NAME (Type) <u>W.S. Murphy</u>				ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave., Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>				ADDRESS <u>1331 E. Montgomery Ave.,</u>		24a. REC'D BY REGISTRAR <u>JAN 6 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
Rockville, Md.							

CERTIFICATE OF DEATH

888

FILED WITH

Blank form area for the Certificate of Death, containing faint horizontal lines for text entry.



890

CERTIFICATE OF DEATH

Reg. Dist. No. 60883

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>1525 CREST ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BRIAN</b> First <b>GERARD</b> Middle <b>McDonald</b> Last 5. SEX <b>Male</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>1/6/61 @ 8:36 PM</b> 9. AGE (In years lost birthday) yrs. <b>1</b> IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> IF UNDER 24 HRS. Hours <b>61</b> Min.				4. DATE OF DEATH 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b> 11. BIRTHPLACE (State or foreign country) <b>TAKOMA PARK, MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Leo William McDonald</b> 14. MOTHER'S MAIDEN NAME <b>DAUENHAUER</b> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b> 16. SOCIAL SECURITY NO. <b>NONE</b> 17. INFORMANT Address <b>Mr. Leo W. McDonald, 1525 Crest Rd. Silver Spring, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Congenital Atherosclerosis</b> DUE TO <b>Prima Fecunda</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>4/6</b> , 19 <b>61</b> , to <b>1/8</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1/8</b> , 19 <b>61</b> , and that death occurred at <b>1:33</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10,620 Ga. Ave.,</b> DATE SIGNED <b>1/9/61</b> ACTUAL SIGNATURE <b>Herbert J. Jacobs</b> M.D. <b>10,620 Ga. Ave.,</b> DATE SIGNED <b>1/9/61</b> PHYSICIAN'S NAME (Type) <b>HERBERT J. JACOBS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>1/10/61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CATHOLIC CEMETERY</b> 22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, Inc.</b> ADDRESS <b>SILVER SPRING, MD.</b> 24a. REC'D BY REGISTRAR <b>JAN 12 61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

891

## CERTIFICATE OF DEATH

00884

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakobs Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>31 days</u>		d. STREET ADDRESS <u>1307 DATE DRIVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Dan &amp; Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>CARROL</u> Last <u>McGaha</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-97</u>
9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail yard master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>John W. McGaha</u>		14. MOTHER'S MAIDEN NAME <u>Hettie BRISLIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>p t hospital record.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Urinary Bladder</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>1/31/61</u> , that (I) (we) last saw the deceased alive on <u>1-31-1961</u> , and that death occurred at <u>7:55 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Hare</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert H. Hare M.D.</u>		22d. ADDRESS <u>7600 Carroll Ave., Ti Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lovettsville Union Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Lovettsville, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Giska</u> INC. ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>FEB 7 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

102

1995

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

892

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00885

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>12 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Chas.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b> d. STREET ADDRESS <b>Apt. 6L, River View Village</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Kevin</b> Middle <b>MC GARRY</b> Last <b>MC GARRY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-9-61</b>	
9. AGE (In years last birthday) yrs.		10. UNDER 1 YEAR Months <b>12</b>		11. UNDER 24 HRS. Days <b>12</b>		12. HOURS <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Edward R. McGarry</b>				14. MOTHER'S MAIDEN NAME <b>Lucilie Talbot</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(f) Edw. R. McGarry, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>570-3 Volvulus, Small bowel infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Jan. 9</b> <b>4:15 AM</b> to <b>Jan. 21</b> , 19 <b>61</b> that <del>he</del> (we) last saw the deceased alive on <b>Jan. 21</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. D. Hooper</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-21-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. D. HOOPER, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Collins Funeral Home, 3821 14th St., NW, WashDC</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

2051272XV6

100

1991

Reviews (1991)

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

STOCKS, BONDS, AND CRYPTOCURRENCY

11-15-1

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1998



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

893

CERTIFICATE OF DEATH

60886

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>7 weeks</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>9 Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ednor</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>2000 Cedar Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Field</b> Last <b>Mc Laury</b>		4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/12/1890</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Advertising Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroads</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Henry Mc Laury</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Murdock Washburn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>718-10-7499</b>		17. INFORMANT <b>hospital records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma left lung</b> <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastases to Rt. lung, liver, kidney</b> (c) <b>and lymph nodes.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.					
22a. SIGNATURE <b>A. D. Bonifant</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT</b>		22d. ADDRESS <b>Sandy Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/27/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODSIDE CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>BRINKLOW, MARYLAND</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Jiska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 31 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Kinn</b>					

333

NAME: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
RACE: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

894

00887

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
c. LENGTH OF STAY in 1b <u>6 1/2 hrs.</u>				d. STREET ADDRESS <u>4330 Chesapeake St. N.W.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Milton</u> Last <u>McQueen</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/11/1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James C. McQueen</u>				14. MOTHER'S MAIDEN NAME <u>Sally Phillips</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>578-10-2961</u>			
17. INFORMANT <u>Mrs. Mary Barrow (daughter)</u>				Address <u>5516 Center St., Ch. Ch. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure due to coronary artery disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this physician) attended the deceased from <u>7-29-55</u> to <u>Jan 30, 1961</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Jan 30, 1961</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>George A. Gray, Jr.</u> M.D.				22b. DATE SIGNED <u>1/30/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>George A. GRAY, JR.</u>				22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>				25a. REC'D BY REGISTRAR <u>JAN 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

of Mrs.

Suburban Hospital

22/11/1963

U.S.A.

Rep. D. C.

Minister of

Barren

James C. Buchanan

Barry Phillips

State Center, D.C.  
Ch. Ch. Rd.

678-10-0-0 Mrs. Mary Barker (daughter)

no

1

The S. H. since Dr. Washington, D. C.  
Jan 31 64  
Funeral Rep. 101 W. Lincoln Cemetery  
Jan 31 64

895

## CERTIFICATE OF DEATH

Reg. Dist. No.

00888

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b> <b>47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SANITARIUM &amp; HOSP</b>				d. STREET ADDRESS <b>6101-16<sup>th</sup> STREET - N.W.</b>			
3. NAME OF DECEASED (Type or print) <b>JACOB</b> First Middle <b>Mehلمان</b> Last				4. DATE OF DEATH <b>January 22</b> 19 <b>61</b> Month Day Year			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 17, 1896</b>	
				9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>LIQUOR STORE</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>MORDECAI MEHLMAN</b>				14. MOTHER'S MAIDEN NAME <b>RACHEL ROSENBAUM</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>578-03-2469</b>			
				INFORMANT <b>FLORENCE F. MEHLMAN</b> Address <b>6101-16<sup>th</sup> ST. N.W.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>8 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hr.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1255</b> to <b>Jan 22</b> 19 <b>61</b> , that I last saw the deceased alive on <b>Jan 10</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1801 Eye St NW, Washington D.C.</b> DATE SIGNED <b>1/22/61</b>							
ACTUAL SIGNATURE <b>Cyril A. Schulman</b> M.D.				PHYSICIAN'S NAME (Type) <b>Cyril A. Schulman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-25-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Mem. Cem. Hyattsville Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS - 3501-14<sup>th</sup> ST NW</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Frank Broschart. Notified  
and approves my certification  
Legit. ~~Reproduction~~ and  
1/22/61.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
e. COUNTY				e. STATE			
MONTGOMERY				MARYLAND			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
SILVER SPRING		12 years		SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
208 DEARBORN AVENUE				208 DEARBORN AVENUE			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Day Year	
First Middle Last				Month Day Year			
EMILY AMY MICHAELS				JAN. 25		19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10/16/90 91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOMEMAKER		OWN HOME		JERUSALEM, PALESTINE		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HARRY GARGOUR				FREIDA unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
NO		NONE		Mr. Edward C. Michaels, 208 Dearborn Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (b)							
(a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Month, Day, Year Hour e.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 1/25/61			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
BURIAL		1/26/61		FT. LINCOLN CEMETERY		PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
WARNER E. PUMPHREY, INC.				DATE JAN 31 '61		Arthur E. Frank	
SILVER SPRING, MD.							
<i>Raymond W. Zicka</i>							



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

897

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00890

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darthesda</u>				c. LENGTH OF STAY IN 1b <u>15 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Irene</u> First <u>miles</u> Middle Last				4. DATE OF DEATH <u>Jan. 24 1961</u> Month Day Year			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/30/22</u>	
9. AGE (In years lost birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Tubing Co. operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>machine</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Kenzie Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Miles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>414-16-5285</u>		17. INFORMANT <u>George H. Miles #2 above</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>541.1</u> DUE TO <u>Generalized Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Perforated Duodenal Ulcer</u> (c) <u>40 hrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> 19 <u>61</u> , to <u>1/24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> 19 <u>61</u> , and that death occurred at <u>2</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>WM. R. Moses</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>WM. R. Moses</u>	
22d. ADDRESS <u>1835 Eye St N.W. (D.C.)</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-27-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave. S.E. D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00891

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#8 Crescent Place</u>				d. STREET ADDRESS <u>#8 Crescent Place</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>H.</u> Last <u>MILLARD</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1897</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Law Practice</u>		11. BIRTHPLACE (State or foreign country) <u>OKLA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry H. Millard</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>W.W.I</u>		17. INFORMANT <u>Louis A. Millard</u>		Address <u>Tulsa, Okla.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1946</u> to <u>17 Jan</u> , 1961, that (I) (we) last saw the deceased alive on <u>5 Jan</u> , 1961, and that death occurred at <u>12:15</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>M.B. Queen</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>17 Jan 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.B. QUEEN M.D.</u>				22d. ADDRESS <u>7112 Willow Ave Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 20, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON D C</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraw...</u> ADDRESS <u>254 Carroll St NW</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw...</u>	

1/17/61 Dr. Queen contacted Dr. Frank J. Broschart, Dep. Med. Examiner,  
and Dr. Broschart approved of Dr. Queen signing this certificate.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

899

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00892

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7228 Spruce Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. &amp; Hosp.</u>				d. STREET ADDRESS <u>Takoma Park, Md. 1</u>			
3. NAME OF DECEASED (Type or print) <u>Louise Weisenthal Miller</u>				4. DATE OF DEATH <u>1-14-1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-6-90</u>	
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Reconstruction Finance Corp.</u>			
11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>David Miller</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Robertson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>yes</u>			
17. INFORMANT Address <u>Mr. Robert D. Miller, 12,904 Grenoble Dr. Rockville, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis of liver</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>one month</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from <u>March 22, 1958</u> to <u>January 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 13, 1961</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Arnon H. Traum</u>				22b. DATE SIGNED <u>Jan 16 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>ARNON H. TRAUM</u>	
22d. ADDRESS <u>8237 Georgia Ave., Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>1/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pomfrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>JAN 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
901  
CERTIFICATE OF DEATH

Reg. Dist. No.

00894

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>900 DOMER AVENUE</b>				d. STREET ADDRESS <b>900 DOMER AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>L.</b> Last <b>MOON</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 16, 1878</b>	
9. AGE (In years lost birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>CASTEL, GERMANY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CONRAD SCHULTZ</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA WACHTMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>Mrs. Donald F. Poole, 900 Domer Ave. Takoma Park, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Sclerosis Heart Disease</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Chronic Nephritis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>34000</b> <b>3400</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic Mellitus</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3/7/57</b> , 19 to <b>5/14/61</b> , 19, that I last saw the deceased alive on <b>5/14/61</b> , 19, and that death occurred at <b>12:50</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James G. O'Keefe</b>				ADDRESS (Street, city or town, state) <b>4501 Conn Ave NW Wash. D.C.</b>			
PHYSICIAN'S NAME (Type) <b>James G. O'Keefe</b>				DATE SIGNED <b>5/17/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>JAN. 17, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LOUDOUN PARK CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>				22e. REC'D BY REGISTRAR <b>Raymond A. Ziska</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>			

CERTIFICATE OF DEATH

301

NEW YORK AND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
AGE  
SEX  
RACE  
MARRIAGE  
OCCUPATION  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF REGISTRAR  
DATE OF REGISTRATION

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

STATE OF NEW YORK  
COUNTY OF [illegible]  
[illegible]  
[illegible]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

18  
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

902 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66895

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>M</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN lb <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montg. General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Highland</u> d. STREET ADDRESS <u>Forest Edge Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bettymae</u> First Middle Last 4. DATE OF DEATH <u>Jan 1, 1961</u> Month Day Year		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11/16/1922</u> 9. AGE (In years last birthday) <u>38</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SCHOENEMAN</u> <u>Geo. J. Schoeneman</u>		14. MOTHER'S MAIDEN NAME <u>Lorena Rouse</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-20-2187</u> 17. INFORMANT <u>Hosp. Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemo-pericardium</u> 823X DUE TO (b) <u>Rupture of pulmonary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Crushed chest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) <u>Undetermined if driver or passenger in car which struck tree</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:20 p.m.</u> <u>1/1/61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u> 20f. (City or town) (County) (State) <u>Norwood Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1/1/61</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/4/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u> 22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JAN 6 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
903 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9128 Walden Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>EDNA BROWNING MOORE</u>			4. DATE OF DEATH Month <u>1</u> Day <u>-</u> Year <u>1961</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>2-3-76</u>			9. AGE (In years last birthday) <u>84</u> yrs.			IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>INDianna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL Wooten</u>						14. MOTHER'S MAIDEN NAME <u>unknown Stevenson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>None</u>						16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Gen. in-law</u>		Address <u>Sauco</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>Generalized arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>July 59</u> , 19 <u>59</u> , to <u>Jan 61</u> , 19 <u>61</u> ; that (I) <del>(we)</del> last saw the deceased alive on <u>Dec 31</u> , 19 <u>60</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/1/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>						22d. ADDRESS <u>217 University Blvd E. S.S. Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>			23b. DATE HEREOF <u>1/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		23d. LOCATION (City, town or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>		25b. REGISTRAR'S SIGNATURE	

203

STANDARD

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1  
Page 4  
death. Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
904  
CERTIFICATE OF DEATH

00897

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>53 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. &amp; Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Jessie Glessner Moore</i>				4. DATE OF DEATH <i>January 24 1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>November 1, 1875</i>	
9. AGE (In years lost birthday) <i>85 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Glessner</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Daddysman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Hospital Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X Carcinoma of Lung, Bones, &amp; Carcinoma of R Breast</i> DUE TO (b) <i>30 Yrs ago</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12/1/1960</i> to <i>1/24/1961</i> , that (I) (we) last saw the deceased alive on <i>1/24/1961</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Chas H. Wolohow</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Chas H. Wolohow</i>				22d. ADDRESS <i>500 Underwood St. N.W. Wash. D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>JAN 26 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEM</i>		23d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Kraus</i>				ADDRESS <i>254 Carroll St. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 26 '61</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00898

905

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>3713 Kennedy Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Vincent</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 8, 1907</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Foreman</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Morris</u>				14. MOTHER'S MAIDEN NAME <u>(Unknown) Tyler (Sarah Mandanyohl)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-05-2118</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Respiratory Insufficiency</u> DUE TO (c) <u>Carcinomatous (Bronchogenic) Myelopathy</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>December 6</u> , 19 <u>60</u> , to <u>January 2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>January 2</u> , 19 <u>61</u> , and that death occurred at <u>6:10A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>1/2/61</u> NATIONAL INSTITUTES OF HEALTH <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>Forbes H. Norris</u> M.D.				PHYSICIAN'S NAME (Type) <u>Forbes H. Norris, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>January 4, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00899

906

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>35 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>4000 Massachusetts Ave., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Broder</b> Last <b>MOSS</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-25-01</b>		9. AGE (In years lost birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Andrew MOSS</b>				14. MOTHER'S MAIDEN NAME <b>Carolyn KOBBELEOR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1923 to 1953 056-30-7225</b>		17. INFORMANT Address <b>(W) Mrs. Dorothy Moss, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>193.0</b> IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Increased intracranial pressure</b> DUE TO (c) <b>Malignant brain tumor.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 27</b> <b>5:40PM</b> to <b>Jan. 31</b> <b>1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 31</b> <b>1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. H. Miller</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		22c. DATE SIGNED <b>2-1-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. H. MILLER, LT, MC, USN</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-3-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b> ADDRESS <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

# CERTIFICATE OF DEATH

208

State of Colorado

Washington

19 days

Edwards (Hazel)

U. S. Naval Hospital

400 Pennsylvania Ave., N.W.

January 31

1943

John

John

60

1-27-43

Contracted

Male

USA

New York

U. S. Navy

Officer

Carlton K. H. H. H.

John, Edwin Ross

Yes 1922 to 1943 (1922-1943) (1) Mrs. Edwin Ross, same as above

Washington, D.C.

Edwards (Hazel)

Edwards (Hazel)

Jan. 31

Jan. 31

Jan. 31

2

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

Edwards

Edwards

2-3-43

Edwards

U. S. Naval Hospital, Bethesda, Md.

10 1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD 907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>unknown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				d. STREET ADDRESS <b>6 Sedgewick Lane</b>			
3. NAME OF DECEASED (Type or print) First <b>Gerald</b> Middle <b>W.</b> Last <b>Movius</b>				4. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/27/07</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>25</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Writer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Dakota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert Movius</b>				14. MOTHER'S MAIDEN NAME <b>Anna Murry</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>501-01-5706</b>		17. INFORMANT <b>Eleanor, wife</b> Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Edema</b> 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Subdural hematoma, left</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped on ice &amp; fell to street</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>5</b> a.m. <b>1-19</b> 1961 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>	
20f. (City or town) <b>Washington</b>				20g. (County) <b>De</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschert</b>				M.D. <b>FRANK J. Broschert</b>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>				DATE SIGNED <b>1-25-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/3/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Washington, D. C.</b>				(State)			
23. FUNERAL DIRECTOR <b>The S.H.Hines Co. Washington, D. C.</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 2 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

CG901

908

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville</b>				c. LENGTH OF STAY IN 1b <b>75 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bemulah</b> Middle <b>Ann</b> Last <b>Munger</b>				4. DATE OF DEATH <b>Jan. December 8 19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 12-1881</b>	
9. AGE (In years lost birthday) <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper---Own home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>John B. Munger</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Huffman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NONE</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Fred Campbell ,Poolesville,Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Bronchial,</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Atherosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 January, 1961</b> to <b>8 January, 1961</b> , that I last saw the deceased alive on <b>2 January 19 61</b> , and that death occurred at <b>2 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gordon M. Smith</b>				ADDRESS (Street, city or town, state) <b>Barnesville</b> DATE SIGNED <b>8 Jan 61</b>			
PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>				<b>Barnesville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/10/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>				ADDRESS <b>Barnesville</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 11 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kimes</b>			

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CERTIFICATE OF DEATH

County of Montgomery State of Maryland

I, John H. Hunter, Registrar of the County of Montgomery, do hereby certify that on the 12 day of December, 1912, at Booleville, in the County of Montgomery, State of Maryland, John H. Hunter, of the County of Montgomery, State of Maryland, died, at his own home, of the following named disease, to-wit: Heart disease, at the age of 68 years, male, white, single, born December 12-1842, at Booleville, Maryland.

Witness my hand and the seal of said County, at Booleville, this 12 day of December, 1912.

John H. Hunter  
Registrar

Attest:  
Edith M. Smith  
 Clerk

Gordon H. Smith  
 Registrar

Booleville, Maryland  
December 12, 1912

## CERTIFICATE OF DEATH

Reg. Dist. No. 00902

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONT.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRLAND</b>				c. LENGTH OF STAY IN 1b <b>8/57 to 1/14/61</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRLAND NURSING Home</b>				d. STREET ADDRESS <b>4504 Walsh St.</b>			
3. NAME OF DECEASED (Type or print) <b>Louise R Niess</b>				4. DATE OF DEATH <b>Jan. 14, 1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUN 26 1885</b>	9. AGE (In years lost birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S</b>
13. FATHER'S NAME <b>JAMES RICHARDSON</b>				14. MOTHER'S MAIDEN NAME <b>LUBERTA DEENER.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. } (b) <b>Hypertensive heart disease</b> DUE TO (c) <b>Diabetes mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>years.</b> <b>5 years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Feb. 1956</b> , to <b>Jan. 12, 1961</b> , that I last saw the deceased alive on <b>Jan 12, 1961</b> , and that death occurred at <b>7:25 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C.P. Ryland</b>			ADDRESS (Street, city or town, state) <b>4400-49 St N.W.</b>			DATE SIGNED <b>1-14-61</b>	
PHYSICIAN'S NAME (Type) <b>C.P. RYLAND, M.D.</b>			Washington 16 DC				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/17/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oakhill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>For + Buchs Son</b>			ADDRESS <b>3034 M St NW</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 00903

910

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>543 W. Montgomery Avenue</b>			d. STREET ADDRESS <b>543 W. Montgomery Avenue</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ROBERT HARRY OAKES</b>			4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/21/1895</b>		9. AGE (In years last birthday) <b>65</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>
13. FATHER'S NAME <b>Robert H. Oakes</b>			14. MOTHER'S MAIDEN NAME <b>Mary Hunter</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW 1</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive heart disease</b> DUE TO <b>20 years</b> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>March 1958</b> to <b>Jan 20, 1961</b> , that I last saw the deceased alive on <b>Jan 20, 1961</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W. G. Hall</b>			ADDRESS (Street, city or town, state) <b>615 W. Montgomery Ave. Rockville, Md.</b>		
DATE SIGNED <b>1/20/61</b>					
PHYSICIAN'S NAME (Type) <b>W. G. Hall - 615 W. Montg. Ave., Rockville, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/24/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
				22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home</b>			ADDRESS <b>1331 E. Montgomery Avenue, Rockville, Maryland</b>		
24a. REC'D BY REGISTRAR DATE <b>JAN 25 '61</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

970

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON



911

CERTIFICATE OF DEATH

Reg. Dist. No.

00904

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(NONE) 719 Woodburn Rd.</u>				d. STREET ADDRESS <u>719 Woodburn Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Winand</u> Last <u>O'BRIEN</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 19, 1862</u>	
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Winand</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Gault</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mary Kirkley</u> Address <u>719 Woodburn</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>January, 1960</u> to <u>Dec 31, 1960</u> , that I last saw the deceased alive on <u>Dec 31, 1960</u> , and that death occurred at <u>9A</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>809 Viers Hill Rd. Rockville, Md.</u>				DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Herman Chapazini</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Herman C. Chapazini</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler-1331 E. Montg. Ave.</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

Rockville, Md.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN		17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF FUNERAL HOME		19. SIGNATURE OF CHURCH		20. SIGNATURE OF OTHER					

PROXY CERTIFICATION

This certificate is to be filled out by the physician or other qualified person who has attended the deceased and who is satisfied that the deceased has died. It is to be filled out in duplicate, one copy to be retained by the physician or other qualified person and the other copy to be forwarded to the Registrar of the State Department of Health. The Registrar will issue a duplicate copy of this certificate to the funeral home or other person who has charge of the burial of the deceased. The Registrar will also issue a duplicate copy of this certificate to the next of kin of the deceased. The Registrar will also issue a duplicate copy of this certificate to the burial official. The Registrar will also issue a duplicate copy of this certificate to the funeral home. The Registrar will also issue a duplicate copy of this certificate to the church. The Registrar will also issue a duplicate copy of this certificate to other persons who may be interested in the death of the deceased.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# 912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00905

1. PLACE OF DEATH COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>P. Y.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>3311 Standard Street</u>			
3. NAME OF DECEASED (Type or print) <u>George Timothy O'Neill</u>				4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1904</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>U.S. TARIFF COMMISSION</u>		10. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George O'Neill</u>				14. MOTHER'S MAIDEN NAME <u>Ida Belle Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Name <u>Mrs. Laura B. O'Neill</u> Address <u>3311 Standard St. Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-30-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2/2/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEMETERY</u>	
				22d. LOCATION (City, town, or country) (State) <u>PRINCE GEORGE COUNTY, MD.</u>			
23. FUNERAL DIRECTOR <u>PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

MEDICAL CERTIFICATION

IN WYOMING I HAVE BEEN ADVISED BY THE  
DIVISION OF REVENUE THAT THE FOLLOWING  
PERSONS ARE THE OWNERS OF THE FOLLOWING  
PROPERTY AND ARE THE PERSONS WHOSE NAMES  
ARE LISTED IN THE FOLLOWING LIST OF  
PROPERTY OWNERS IN THE STATE OF WYOMING

STATE OF WYOMING  
DIVISION OF REVENUE

(1)

WYOMING DIVISION OF REVENUE  
STATE OF WYOMING

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

66906

913

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN 1b <u>1 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4105 Stanford St</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Longview</u> d. STREET ADDRESS <u>1620 Westside Highway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>Peairs</u>			<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>11</u> Year <u>1961</u>				
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5-16-1875</u>			
<b>9. AGE</b> (in years last birthday) <u>85</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>25</u>		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Business Prop.-Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Laundry</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Ohio</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>David Allen Peairs</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Esther Drennan</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____			
<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> <u>Daughter</u> <u>Mrs. Ronald C. Kinsey</u>		<b>Address</b> <u>Same as Item #1</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____		<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a. m. _____ p. m. _____					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>Jan 11, 1961</u>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-transit</u>		<b>22b. DATE THEREOF</b> <u>1-12-61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Longview Mem. Park Cem.</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Cowlitz County, Wash.</u> (State) _____		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>					
<b>24a. REC'D BY REGISTRAR</b> DATE <u>JAN 13 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PRESENT RESIDENCE</p> <p>12. DATE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. PLACE OF DEATH</p> <p>15. CAUSE OF DEATH</p> <p>16. MANNER OF DEATH</p> <p>17. SIGNATURE OF EXAMINER</p> <p>18. SIGNATURE OF WITNESSES</p> <p>19. SIGNATURE OF FUNERAL HOME</p> <p>20. SIGNATURE OF CORONER</p> <p>21. SIGNATURE OF JUDGE</p> <p>22. SIGNATURE OF CLERK</p> <p>23. SIGNATURE OF NOTARY</p> <p>24. SIGNATURE OF ATTORNEY</p> <p>25. SIGNATURE OF PHYSICIAN</p> <p>26. SIGNATURE OF NURSE</p> <p>27. SIGNATURE OF CHAPLAIN</p> <p>28. SIGNATURE OF MINISTER</p> <p>29. SIGNATURE OF RABBI</p> <p>30. SIGNATURE OF OTHER</p>	
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

914

00907

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leighton H. Peebles</u>				4. DATE OF DEATH Month Day Year <u>January 28, 1961 19</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/83</u>		9. AGE (In years lost birthday) <u>77</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>William Peebles</u>				14. MOTHER'S MAIDEN NAME <u>Annie L. Bradbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-38-4790</u>		17. INFORMANT Address <u>Emilie Peebles-daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia, right, severe, multiple attacks</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalised</u> DUE TO (c) <u>Essential Hypertension, severe</u>							INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u> <u>10 yrs +</u> <u>10 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis, bilateral</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 27</u> 19 <u>61</u> , to <u>Jan 28</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 27</u> 19 <u>61</u> , and that death occurred at <u>3:24</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp</u>				22b. DATE <u>1-28-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>	
22d. ADDRESS <u>4740 Chevy Chase Dr</u>				22e. CITY, STATE, AND ZIP <u>Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Caroline L. Thomas</u>	

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or letter containing several paragraphs of text, possibly discussing a business matter or a report. Some words like "The following information" and "is being furnished" are faintly visible.]

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

915

CERTIFICATE OF DEATH

00908

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>58 hr.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N.W. Washington, D.C.</u>		d. STREET ADDRESS <u>8229 E. Beach Drive,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Perlis</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 15 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13, 1961</u>
9. AGE (In years last birthday) yrs. <u>2</u> Months <u>10</u> Days <u>10</u> Min.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marvin Elliott Perlis</u>		14. MOTHER'S MAIDEN NAME <u>Edith (Nina) Plotnick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>father</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS OF NEWBORN</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>PREMATURITY</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 13</u> 19 <u>61</u> , to <u>JAN. 15</u> 19 <u>61</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>JAN. 14</u> 19 <u>61</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Stanley Gould</u>		22b. DATE SIGNED <u>JAN. 15, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stanley Gould, M. D.</u>		22d. ADDRESS <u>3829 PLYERS MILL ROAD, KENSINGTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1-15-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hospital, Takoma Park, Md.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Washington San &amp; Hospital</u>		25a. REC'D BY REGISTRAR <u>JAN 17 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>C. H. &amp; H. Hare</u>			

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CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G281 2-14-61 et

916

## CERTIFICATE OF DEATH

00909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>44 BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - 4502 Avamere St.</u>		d. STREET ADDRESS <u>4502 AVAMERE ST</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>S</u> Last <u>PERRY</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 4 1870</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Kendrick Herndon</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. William Wine</u>		Address <u>4502 Avamere St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arterio Sclerotic Heart Dis</u> <u>443X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 11, 1961</u> to <u>1/30, 1961</u> , that I last saw the deceased alive on <u>Jan 27, 1961</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bethesda, Md</u> DATE SIGNED <u>1/30/61</u> ACTUAL SIGNATURE <u>A. J. Brennan</u> M.D. PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-2-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fredericksburg</u>		22d. LOCATION (City, town or county) (State) <u>Fredericksburg Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>		ADDRESS <u>4812 Dupont Hwy Wash DC</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06910

917

Item 3 Film 6281 2-14-61 et

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>2 days</b>		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>34 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>			d. STREET ADDRESS <b>3003 Weller Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Helen B. Petherbridge</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>24</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/83</b>		9. AGE (In years last birthday) <b>77 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charlie Burch</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Walter</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Husband (Edward)</b> Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchitis pneumonia</b> (c) <b>Emphysema</b>					INTERVAL BETWEEN ONSET AND DEATH <b>50 days</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10620 Georgia Ave NW</b>	
20f. (City or town) <b>WASHINGTON DC</b>		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 15/58</b> to <b>Jan 24/61</b> that (I) (we) last saw the deceased alive on <b>Jan 23/61</b> and that death occurred at <b>5:4 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>John J. Curry</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/24/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John J. Curry</b>		22d. ADDRESS <b>10620 Georgia Ave NW</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-26-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>	
23d. LOCATION (City, town, or county) <b>WASHINGTON DC</b>		23e. (State)		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. FRANK JOY</b>		ADDRESS <b>5406 ILLINOIS AVE NW</b>		25a. REC'D BY REGISTRAR <b>DATE 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		25c. (City, town, or county)			

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

213

County of \_\_\_\_\_  
State of \_\_\_\_\_  
Name of Deceased \_\_\_\_\_  
Age \_\_\_\_\_  
Sex \_\_\_\_\_  
Race \_\_\_\_\_  
Date of Death \_\_\_\_\_  
Place of Death \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
Manner of Death \_\_\_\_\_  
Signature of Physician \_\_\_\_\_  
Signature of Coroner \_\_\_\_\_  
Signature of Registrar \_\_\_\_\_

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00911

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home</b>				d. STREET ADDRESS <b>1 8716 COLESVILLE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MENZIE</b> Middle <b>E.</b> Last <b>PITTMAN</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/23/82</b>	
9. AGE (In years lost birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Div. Foreman (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of Engraving &amp; Printing</b>		11. BIRTHPLACE (State or foreign country) <b>HANCOCK, MARYLAND</b>	
13. FATHER'S NAME <b>GEORGE PITTMAN</b>				14. MOTHER'S MAIDEN NAME <b>VALLORA SHIVES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Elair C. Pittman, 4321 Wright Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19 47 to 9 Jan 19 61</b> that (I) (we) last saw the deceased alive on <b>9 Jan 19 61</b> and that death occurred at <b>935 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William D. Aud</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>				22d. ADDRESS <b>9006 Colesville Rd., Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 16 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

CERTIFICATE OF DEATH

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SEVERAL OTHERS

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WHO COULD BE IDENTIFIED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

919

CERTIFICATE OF DEATH

60912

Items 8, 9 Film 6251 2-10-61 et

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>79 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Waldwick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldwick</b> d. STREET ADDRESS <b>58 Waldwick Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hazel Florence Podgorsky</b>		4. DATE OF DEATH Month Day Year <b>January 28, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1927</b> <b>November 3, 1928</b>
9. AGE (In years lost, birthday) <b>32 33 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Morrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staphylococcal Septicemia</b> DUE TO <b>726.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Polymyositis Of Unknown Cause</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 Days</b> <b>3 Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 10, 1960</b> to <b>January 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>January 28, 1961</b> , and that death occurred at <b>7:20PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert P. Levine</b>		22b. DATE SIGNED <b>1/29/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert P. Levine M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 1-29-61</b>		23b. DATE THEREOF <b>1-29-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Maryrest Cemetery.</b>		23d. LOCATION (City, town, or county) (State) <b>Darlington, New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 2 '61</b>	
ADDRESS <b>Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

THE HOUSE OF DEATH

New Jersey

Atlantic City

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

920

## CERTIFICATE OF DEATH

Reg. Dist. No.

00913

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>80 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1919 North Daniel Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Frances</u> Last <u>Pote</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1913</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Management Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Pote</u>				14. MOTHER'S MAIDEN NAME <u>Anna McKenna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>572-32-4822</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Extensive metastatic disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Adenocarcinoma of breast</u> (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 1/2 years</u> <u>1 1/2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 20, 1960</u> to <u>January 8, 1961</u> , that I last saw the deceased alive on <u>January 8, 1961</u> , and that death occurred at <u>10:45 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>Michael Z. Lazor</u> M.D.		PHYSICIAN'S NAME (Type) <u>Michael Z. Lazor, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/12/61</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>  </u> ADDRESS <u>475-H. N. W. Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farnsworth</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1234

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00914

921

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vandling</b> <b>75X-3</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>308 Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print)		First <b>Barbara</b> Middle <b>Ann</b> Last <b>Pribula</b>		<b>4. DATE OF DEATH</b>		Month <b>January</b> Day <b>9</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>December 28, 1928</b>	
<b>9. AGE</b> (In years lost birthday) yrs. <b>32</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Joseph Fotusky</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Eva Dayton</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>169-24-3316</b>		<b>17. INFORMANT</b> <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>410X</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Mitral Stenosis, Mitral Insufficiency</b> DUE TO (c) <b>Rheumatic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> ? ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>January 5, 1961</b> , to <b>January 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>January 9, 1961</b> , and that death occurred at <b>11:32 P.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Michael W. Brandriss</b>				<b>22b. DATE</b> <b>1/10/61</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Michael W. Brandriss, M.D.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>1/14/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Agnes Cemetery</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b>				<b>ADDRESS</b> <b>Bethesda, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 11 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Pumphrey</b>							

CERTIFICATE OF DEATH

321

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00915

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>434 Jefferson Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Carol</u> Middle <u>Lynn</u> Last <u>Price</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>7</u> Year <u>19 61</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>January 8, 1958</u>		<b>9. AGE</b> (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> Hours <u>61</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Child</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Harold H. Price</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Barbara De Grange</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary and gastro-intestinal hemorrhage</u> DUE TO <u>204.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute lymphatic leukemia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that I attended the deceased from</b> <u>December 29, 1960</u> , to <u>January 7, 1961</u> , that I last saw the deceased alive on <u>January 7, 1961</u> , and that death occurred at <u>12:45 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>1/7/61</u> ACTUAL SIGNATURE <u>Jerome B. Block</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>JEROME B. BLOCK, M.D.</u> <u>Bethesda 14, Maryland</u>													
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>1/9/1961</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rest Haven Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Hagerstown, Maryland</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Suter - Rouzer Funeral Home</u> ADDRESS <u>Hagerstown, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>JAN 9 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. [unclear]</u>					

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Signature of Physician

Signature of Registrar



VS. A15ME  
SM 7/59

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-27-61

FOR STATE HEALTH DEPT.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wash. San &amp; Hosp.</b>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>19102 Warren St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth Principle</b>				4. DATE OF DEATH <b>1-12-61</b>				5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>February 25 1918</b>				9. AGE (In years last birthday) <b>42</b>				10. USUAL OCCUPATION (Give kind of work and duration of working life, even if retired) <b>Housewife - own home</b>				11. BIRTHPLACE (State or foreign country) <b>Bluefield West Virginia U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Perry Graham</b>												14. MOTHER'S MAIDEN NAME <b>Elizabeth Mary Spurrier</b>																											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>												16. SOCIAL SECURITY NO. <b>yes</b>												17. INFORMANT <b>Mrs. Claude Principle</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PENDING</b> DUE TO <b>Barbiturate poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>970.2</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)																					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE <b>Frank J. Blosch</b>												M.D. <b>FLANK J. BLOSCH</b>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>															
EXAMINER'S NAME (Type) <b>FRANK J. BLOSCH</b>												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												DATE SIGNED <b>1-12-61</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>												22b. DATE THEREOF <b>1/16/61</b>						22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>						22d. LOCATION (City, town, or country) (State) <b>PRINCE GEO. COUNTY, MD.</b>															
23. FUNERAL DIRECTOR <b>RAYMOND E. BUSH</b>												ADDRESS <b>SILVER SPRING, MD.</b>												24a. REC'D BY REGISTRAR <b>JAN 17 '61</b>						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>									

923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00916



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

924

00917

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>27 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>34 Silver Spring, Md.</b> d. STREET ADDRESS <b>112609 Littleton St.</b>	
3. NAME OF DECEASED (Type or print) <b>James (NMI) Ramsay</b>		4. DATE OF DEATH <b>Jan. 7 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-19-85</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant-Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Riggs Market</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>	
13. FATHER'S NAME <b>Alexander Ramsay</b>		14. MOTHER'S MAIDEN NAME <b>Mary unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> (c) <b>Arteriosclerotic Heart Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>Bronchopneumonia and Congestive Heart Failure</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>12-11</b> , 1960, to <b>1-7</b> , 1961, that (I) (we) last saw the deceased alive on <b>1-6</b> , 1961, and that death occurred at <b>10:05 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Stuart L. Nelson</b>		22b. DATE SIGNED <b>1-7-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stuart L. Nelson</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1/10/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>	23d. LOCATION (City, town or county) <b>PRINCE GEO. COUNTY, MARYLAND</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>JAN 12 '61</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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925

CERTIFICATE OF DEATH

Reg. Dist. No.

66918

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>702 Burgundy Drive</b>				d. STREET ADDRESS <b>702 Burgundy Drive.</b>			
3. NAME OF DECEASED (Type or print) <b>Annabel Eva Range.</b> Middle Last <b>Annabel Eva Range</b>				4. DATE OF DEATH <b>January 16th.</b> Month Day Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11th. 1920</b>	9. AGE (In years last birthday) yrs. <b>40</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Arendes</b>				14. MOTHER'S MAIDEN NAME <b>Anna F. Nally.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown.</b>		INFORMANT <b>Rockville, Maryland.</b> Address <b>Fredrick P. Range 702 Burgundy Drive,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>155.0</b> IMMEDIATE CAUSE (a) <b>Leukemia</b> DUE TO <b>Carcinoma of Lungs Primary</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>10 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>March 19 60</b> to <b>Jan 16 61</b> , that I last saw the deceased alive on <b>Jan 8 19 61</b> , and that death occurred at <b>1601 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Francis T. Sharpe</b> M.D.		ADDRESS (Street, city or town, state) <b>3323 - 0 St. N.W. Washington 7, D.C.</b> DATE SIGNED <b>1-16-61</b>					
PHYSICIAN'S NAME (Type) <b>Francis T. Sharpe M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial.</b>	22b. DATE THEREOF <b>1/19/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph F. Bickelmann</b>		ADDRESS <b>3034 1st St. N.W.</b>		24a. REC'D BY REGISTRAR <b>JAN 19 61</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Hines</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL OFFICE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

926

## CERTIFICATE OF DEATH

00919

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SAN. &amp; Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12601 Colesville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>George Charles Richert</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>1 - 20 1961</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-4-04</u>
<b>9. AGE</b> (In years last birthday) <u>57</u> rs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Secretary</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Charles Richert</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Magdalene Good</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <u>168-05-0070</u>		<b>17. INFORMANT</b> Address <u>Mrs. Margaret Richert - Same as Deceased</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>434.4</u> IMMEDIATE CAUSE (a) <u>Cardiac Disturbance</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO } (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 30 minutes</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>June 10, 1940</u> to <u>Jan 20, 1961</u> ; that (I) (we) last saw the deceased alive on <u>Jan 18, 1961</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>W.B. Wardrop M.D.</u>		<b>22b. DATE SIGNED</b> <u>1/20/61</u>	<b>22c. PHYSICIAN'S NAME (Type)</b> <u>W.B. WARDROP M.D.</u>
<b>22d. ADDRESS</b> <u>800 Pershing Ave. Silver Spring Md.</u>		<b>23a. REC'D BY REGISTRAR</b> DATE <u>JAN 25 '61</u>	
<b>23b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>RICHLAND CEMETERY</u>	
<b>23d. LOCATION</b> (City, town or county) (State) <u>DRYSDALE, PENNSYLVANIA</u>		<b>23e. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>TRANS. &amp; BURIAL</u>	
<b>23f. DATE THEREOF</b> <u>1/24/61</u>		<b>23g. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WARNER E. PUMPHREY, INC.</u>	
<b>23h. ADDRESS</b> <u>SILVER SPRING, MD.</u>		<b>23i. NAME OF CEMETERY OR CREMATORY</b> <u>RICHLAND CEMETERY</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

927

CERTIFICATE OF DEATH

Reg. Dist. No.

66920

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>95 Horners Lane</u>		d. STREET ADDRESS <u>195 Horners Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNETTE R. RICKETTS</u>		4. DATE OF DEATH Month Day Year <u>Jan. 31, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/88</u>
9. AGE (In years last birthday) yrs. <u>72</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George William Riggs</u>		14. MOTHER'S MAIDEN NAME <u>Margaret C. Graham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Mrs Marilyn R. Ingells-Item# 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL METASTASIS</u> <u>170 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>GENERALIZED METASTASIS</u> DUE TO (c) <u>CARCINOMA OF BREAST</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>ONE MONTH</u> <u>ONE YEAR</u> <u>ONE YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCTOBER, 1960</u> , to <u>JAN. 31, 1961</u> , that I last saw the deceased alive on <u>JANUARY 30, 1961</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>310 W. MONTGOMERY AVE 31 JAN 1961</u>	
PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>		<u>Rockville, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		ADDRESS <u>1321 E. Montgomery Ave. Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 2 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BOSTON

1

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

928

CERTIFICATE OF DEATH

Reg. Dist. No.

00921

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> c. LENGTH OF STAY IN 1b <b>3 1/2 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12,610 PARKLAND DRIVE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>33 ROCKVILLE</b> d. STREET ADDRESS <b>12,610 PARKLAND DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MAY</b> First <b>ESTELLE</b> Middle <b>RODGERS</b> Last 4. DATE OF DEATH <b>JANUARY</b> Month <b>17</b> Day <b>1961</b> Year				5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>5/17/1900</b> 9. AGE (In years last birthday) <b>60</b> yrs. IF UNDER 1 YEAR: Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b> 11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WILLIAM E. SMITH</b> 14. MOTHER'S MAIDEN NAME <b>CATHERINE CULLEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <b>NONE</b> 17. INFORMANT <b>Mr. Keith R. Rodgers, 12,610 Parkland Drive</b> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b> <b>17510</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>OVARIAN ADENOCARCINOMA</b> DUE TO (c) <b>8 MOS.</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 MOS.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>JUNE</b> , 19 <b>57</b> , to <b>JAN. 17</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>JANUARY 13</b> , 19 <b>61</b> , and that death occurred at <b>2:30</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>11502 Grandview Ave. M.D.</b> DATE SIGNED <b>1/17/61</b> ACTUAL SIGNATURE <b>Belden R. Reap</b> PHYSICIAN'S NAME (Type) <b>BELDEN R. REAP, M.D. SILVER SPRING, MARYLAND</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>1/20/61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>NAT'L. MEM. PARK CEMETERY</b> 22d. LOCATION (City, town, or county) (State) <b>FALLS CHURCH, VIRGINIA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond H. Glick</b> ADDRESS <b>SILVER SPRING, MD.</b> 24a. REC'D BY REGISTRAR DATE <b>JAN 25 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawa</b>							

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

322

FOR  
HEAL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page



STATE  
TH DEPT.

4 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 929 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66922

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>56 Cherry Chase</u>			
c. LENGTH OF STAY in 1b <u>15 yr</u>				d. STREET ADDRESS <u>4501 Cortland Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4501 Cortland Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edwin Jehu Rose</u>				4. DATE OF DEATH Month Day Year <u>Jan 5 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-9-1887</u>	
9. AGE (in years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Desecum Rose</u>				14. MOTHER'S MAIDEN NAME <u>Alice Wiseman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 1917-1920				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Ruth Rose</u>				Address <u>Item 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. (c) <u></u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>1-5-61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/9/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR The S.H. Hines Co. 2901 14th St., N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

OFFICE OF THE MEDICAL EXAMINER

1900

THE STATE OF NEW YORK  
OFFICE OF THE MEDICAL EXAMINER

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film G281 2-14-61 et

60923

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b>		b. COUNTY <b>Delaware</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>PO Box 29</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b>		Middle <b>Boyd</b>		Last <b>RUTTER</b>		4. DATE OF DEATH Month <b>January</b>		Day <b>29</b>		Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-20-87</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James C. RUTTER</b>						14. MOTHER'S MAIDEN NAME <b>Harriet N. Mc KELVY</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>1905-45</b>		17. INFORMANT <b>Mrs. James Rutter, PO Box 29, Bethany Beach,</b>		Address <b>Delaware</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-9</b> to <b>1-29</b> , 19 <b>61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1-29</b> , 19 <b>61</b> , and that death occurred <b>1150AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Russell Miller Jr., LT, MC, USN</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-29-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Russell Miller Jr., LT, MC, USN</b>						22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-2-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Virginia</b>				23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawlers and Sons Inc. 1756 Penn. Ave. Washington 6, D. C.</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

931

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66924

1. PLACE OF DEATH a. COUNTY <b>Montgomery Md.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Tompkins</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring-Wheaton</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11901 Ga. Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
f. STREET ADDRESS <b>217 West Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George</b> First <b>H.</b> Middle <b>Sabine</b> Last		4. DATE OF DEATH Month <b>1</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-9-1880</b>
9. AGE (In years lost birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>18</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Lorenzo Sabine</b>		14. MOTHER'S MAIDEN NAME <b>Eva Mary Tuttle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Mary Sabine</b>		Address <b>7007 Ga. St. Chevy Chase Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>180 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic lymphoma.</b> DUE TO (c) <b>2 months.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 4</b> 19 <b>61</b> , to <b>Jan 18</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Jan 17</b> 19 <b>61</b> , and that death occurred at <b>2:55</b> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Seruch T. Kimble</b>		22b. DATE SIGNED <b>Jan 18, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>SERUCH T. KIMBLE</b>		22d. ADDRESS <b>929 Plendurgh Dr., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-19-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. A. Humphrey Funeral Home</b>		ADDRESS <b>Bethesda, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JAN 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>	

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

66925

932

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>97 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eugenia</b> Middle <b>SANES</b> Last <b>SANES</b>				4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2-12-10</b>	
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>50</b> Days <b>50</b> Hours <b>50</b> Min.		IF UNDER 24 HRS. Months <b>50</b> Days <b>50</b> Hours <b>50</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Puerto Rico</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Balitinia AYALA</b>				14. MOTHER'S MAIDEN NAME <b>Leona SANES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(D) Mrs. Delbert Gibson, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>174X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Metastatic squamous cell carcinoma</b> (c) <b>Sq. cell carcinoma lower uterine</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yr</b> <b>3 yr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 11, 1960</b> to <b>Jan. 16, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 16, 1961</b> , and that death occurred at <b>2:40 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>R. F. Mading</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-16-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. F. MADING, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. McQuinn</b>				ADDRESS <b>McQuinn, 1820 9th St., NW, WashDC</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>							

051

1

2

1

CERTIFICATE OF DEATH

1934

State of California

County of ( )

City of ( )

Residence of ( )

Age ( )

Sex ( )

Occupation ( )

Marital Status ( )

Cause of Death ( )

Time of Death ( )

Place of Death ( )

Signature of ( )

Signature of ( )

Signature of ( )

Signature of ( )

Signature of ( )

Signature of ( )

Signature of ( )

Signature of ( )

Signature of ( )

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Signature of ( )

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
933  
CERTIFICATE OF DEATH

66926

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>				c. LENGTH OF STAY IN 1b <u>years</u> <u>20</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8011 Glenside Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISA ALBERTA SAXTON</u>				4. DATE OF DEATH Month Day Year <u>Jan. 28 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1867</u>	9. AGE (If years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Park Huron, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Jelbart</u>				14. MOTHER'S MAIDEN NAME <u>Ann Exx</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Anna Hayford (same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension &amp; congestive heart failure</u> (c) <u>fracture</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>Pneumonia</u> <u>fracture</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity, smoking</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/1/50</u> to <u>1/28/61</u> that (I) (we) last saw the deceased alive on <u>1/27/61</u> and that death occurred at <u>11:27</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas H. Wolohan, M.D.</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Chas H. Wolohan</u>	
22d. ADDRESS <u>500 Underwood St. NW. Wash. DC</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>Jan. 31, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>York Lincoln Mausoleum</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>				25a. REC'D BY REGISTRAR <u>JAN 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

934

60927

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>11 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sen. and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>611 Woodside Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edna</u> <u>EARL</u> <u>Schmidt</u>		<b>4. DATE OF DEATH</b> <u>Jan. 15 1961</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/25/76</u>		<b>9. AGE</b> (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>William Bobb</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>unknown Pennypacker</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>				<b>17. INFORMANT</b> <u>Hospital Records</u> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe arteriosclerotic Heart Disease</u> DUE TO (c) <u>Several years</u>												INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary Embolism, Aplastic Anemia, Severe Cerebral Arteriosclerosis</u>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>5/14/1960</u> <sup>10:10</sup> <b>to</b> <u>1/15/1961</u> , <b>that (I) (the) last saw the deceased alive on</b> <u>1/15/1961</u> , <b>and that death occurred at</b> <u>  </u> A.M., <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Russell B. Arnold</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>1/15/61</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Russell B. Arnold M.D.</u>						<b>22d. ADDRESS</b> <u>8801 Coleville Road, Silver Spring, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>1/19/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR HILL CEMETERY</u>							
<b>23d. LOCATION</b> (City, town or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>													
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>JAN 25 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

036

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FOR STATE  
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

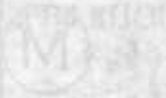
935 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66928

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>5 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10,124 RENFREW ROAD</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>10,124 RENFREW ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARTIN</b>		First <b>Albert</b> Middle <b>SCHWARTZ</b> Last		4. DATE OF DEATH <b>JAN. 6 1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/29/84</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Inspector RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; Milwaukee RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>IOWA</b>			
13. FATHER'S NAME <b>MARTIN J. SCHWARTZ</b>			14. MOTHER'S MAIDEN NAME <b>EMMA MOECKLI</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Selma I. Schwartz, 10,124 Renfrew Rd. Silver Spring, Md.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/6/61</b>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/9/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>	22d. LOCATION (City, town, or country) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>				
23. FUNERAL DIRECTOR <b>WARNER E. PUMPHREY, INC.</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 11 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kious</b>			

MEDICAL CERTIFICATION

THE STATE



DOCTOR

WILLIAM

WILLIAM

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00929

936

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM</u>		d. STREET ADDRESS <u>1727 ARGYLE ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>ALTON</u> Middle <u>RAY</u> Last <u>Sellers</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/1960</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>TAKOMA PARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Sellers</u>		14. MOTHER'S MAIDEN NAME <u>Jacqueline Ginn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Patients Chart.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - Respiratory Failure</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 26</u> , 19 <u>60</u> , to <u>Jan 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 31</u> , 19 <u>60</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilford D. Meyers MD</u>		ADDRESS (Street, city or town, state) <u>8323 Haddon Drive Takoma Park Md</u>	
PHYSICIAN'S NAME (Type) <u>Wilford D Meyers MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 4, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St. NW.</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>		DATE <u>JAN 4 '61</u>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00930

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Be the sda.</u>		c. LENGTH OF STAY IN 1b <u>11 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>CORDELIA</u> Last <u>Shaw</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11</u> <u>July</u> <u>1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done, if any, even if retired) <u>Employed by govt. retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Shaw</u>		14. MOTHER'S MAIDEN NAME <u>XXX ANNE M. FAWCETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Edna L. Shaw</u>		Address <u>21 Shaw Ave. Silver Sp. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.1 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Auricular Fibrillation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>20 yrs.</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 PREMIA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>0</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <u>JAN 7 1961</u> to <u>JAN 19 1961</u> , that (I) (we) last saw the deceased alive on <u>JAN 18 1961</u> , and that death occurred at <u>4:49 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>George B. Patrick Jr.</u> M.D.		22b. DATE SIGNED <u>1-19-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George B. Patrick Jr. M.D.</u>		22d. ADDRESS <u>9221 Colesville Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/23/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>WERNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Curtis S. House</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

938

00931

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>11722 Georgia Ave 37</u> d. STREET ADDRESS <u>Wheaton,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Arthur Lawrence Simpson</u>		<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>17</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>9-27-08</u> <b>9. AGE</b> (In years last birthday) <u>52</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>unemployed.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Arthur L. Simpson Sr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Williams</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Hospital Records -</u> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>331X</u> (e), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>1/5/52</u> 19..... to <u>1/7/61</u> 19....., that (I) (we) last saw the deceased alive on <u>1/17/61</u> 19....., and that death occurred at <u>12M</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Patricia Jameson</u> M.D.		<b>22b. DATE SIGNED</b> <u>1/17/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type)			
<b>22d. ADDRESS</b>		<b>22e. REC'D BY REGISTRAR</b> <b>22f. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Jameson</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial Jan 21, 1961</u>		<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Suitland Md</u>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Lees</u>		<b>24a. ADDRESS</b> <u>Wash. D.C.</u>		<b>24b. DATE</b> <u>JAN 23 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66953

1. PLACE OF DEATH a. COUNTY Montgomery, 1		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park		b. COUNTY District of Columbia	
c. LENGTH OF STAY IN 1b 5 hours		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 1725-17th St., N.W.	
3. NAME OF DECEASED (Type or print) Ella Virginia Souder		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH January 9 1961		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH September 1, 1885		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA American	
13. FATHER'S NAME Thomas Wyn Kopp		14. MOTHER'S MAIDEN NAME Sally Hammerly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 579-30-0252	
17. INFORMANT Washington Sanitarium & Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 900.00 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of skull (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall backward down stairs at sister home	
20c. TIME OF INJURY Month, Day, Year Hour min. 8:53 p.m. 1-8 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8100 Hammond Ave		20f. (City or town) (County) (State) Takoma Park Montg Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschert		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1-12-1961	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		22d. LOCATION (City, town, or country) (State) SUITLAND, MD.	
23. FUNERAL DIRECTOR Joseph Gaudin's Sons, Inc. 1756-Pa. Ave N.W. Wash		24a. REC'D BY REGISTRAR DATE JAN 12 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. REGISTRAR'S SIGNATURE	

DEPT. OF HEALTH  
BOSTON  
1910

NAME  
RESIDENCE  
AGE  
SEX  
DATE OF BIRTH  
DATE OF DEATH  
PLACE OF BIRTH  
CAUSE OF DEATH  
MANNER OF DEATH  
OCCUPATION  
EDUCATION  
RELIGION  
MARRIAGE  
CHILDREN  
SIBLINGS  
PARENTS  
GRANDPARENTS  
OTHER RELATIVES  
FRIENDS  
NEIGHBORS  
OTHER PERSONS  
OTHER INFORMATION

DEPT. OF HEALTH  
BOSTON  
1910



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
941 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
06934											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				d. STREET ADDRESS <u>8733 Carroll ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8733 Carroll ave</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mae Sarah Steele</u>						4. DATE OF DEATH <u>Jan 30 1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-1879</u>		9. AGE (in years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trained nurse, retired</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown Eldridge</u>						14. MOTHER'S MAIDEN NAME <u>unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robt. E Moore (son)</u>				Address <u>Ilion 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CVA, 2 yrs ago</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-30-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-3-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Mem</u>				22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Maryland</u>	
23. FUNERAL DIRECTOR <u>W. M. Chambers Co - Pikesville Md.</u>						24a. REC'D BY REGISTRAR <u>FEB 2 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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DEPARTMENT OF HEALTH  
MEDICAL EXAMINER  
STATE OF CALIFORNIA

FOR STATE  
USE ONLY

*[Faint, mostly illegible handwritten text, likely a medical report or examination notes.]*

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00935

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. LENGTH OF STAY IN 1b <b>37 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HOWA RD</b> Middle <b>R.</b> Last <b>STOCKER</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>16</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/19/84</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jackson Stoker STOCKER</b>				14. MOTHER'S MAIDEN NAME <b>Mary unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no yes</b>				16. SOCIAL SECURITY NO. <b>WW #1</b>		17. INFORMANT <b>Wife - Jennifer</b> Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>416 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic fever (old)</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1-2 yrs</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19 54</b> to <b>16 Jan 19 61</b> , that (I) (we) last saw the deceased alive on <b>15 Jan 19 61</b> , and that death occurred at <b>1:10 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William D. Aud</b>				22b. DATE SIGNED <b>16 Jan 61</b>		22c. PHYSICIAN'S NAME (Type) <b>William D. Aud</b>	
22d. ADDRESS <b>9006 Colesville Rd., Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/20/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHARLES EVANS CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>READING, PENNSYLVANIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY, INC. SILVER SPRING, MD.</b> <b>Raymond A. Giska</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

X

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A LICENSED PHYSICIAN

DATE OF DEATH

Blank area for medical certificate details, including fields for cause of death, location, and signature.

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
943  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00936

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>11 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>911 Rittenhouse St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>D.</u> Last <u>Stoner</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 19, 1894</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>File Clerk (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth De Vaughn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Healed pulmonary tb. ; Rheumatoid Arthritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-22-1960</u> to <u>2-27-1961</u> , that (I) (we) lost <u>saw the deceased alive on 2-26-1961</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>C. H. Higdon</u>				22b. DATE SIGNED <u>1/27/61</u>		22c. PHYSICIAN'S NAME (Type) <u>C. H. Higdon</u>	
22d. ADDRESS <u>Sandy Spring, Md.</u>		22e. M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-28-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Seatons Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Bro. 1661 - Good Hope Rd SE</u>				25a. REC'D BY REGISTRAR <u>WASH 20</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	
25c. DATE <u>JAN 30 '61</u>							

IN SENATE  
JANUARY 11, 1911  
REPORT  
OF THE  
COMMISSIONERS OF THE  
LAND OFFICE  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
MAY 1, 1909  
ALBANY: J. B. LEECH, PRINTERS  
1911

1

THE LAND OFFICE  
ALBANY, N. Y.  
JANUARY 11, 1911  
REPORT  
OF THE  
COMMISSIONERS OF THE  
LAND OFFICE  
IN RESPONSE TO A  
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1911



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00937

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>45</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>5606 Sonoma Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ralph Waldo Strawbridge</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>26</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 29, 1876</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>27</b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <b>Principal-high school</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Neilson Strawbridge</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Duncan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Jennie R. Strawbridge-Same Item #2-Wife</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA,</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>MYOCARDIAL DECOMPENSATION 10 Days</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 Hrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) BRONCHIAL ASTHMA (2) CARCINOMA - RT. LUNG</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1950</b> to <b>1-26</b> , 1961, that (I) ( <del>was</del> ) last saw the deceased alive on <b>1-25</b> , 1961, and that death occurred on <b>1-26</b> , 1961, from the causes and on the date stated above.							
22a. SIGNATURE <b>James W. Lowe</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-26-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES W. LOWE</b>		22d. ADDRESS <b>6601 - GREENTREE RD. BETHESDA</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/28/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Center Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Stewartstown Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				ADDRESS <b></b>		25a. REC'D BY REGISTRAR DATE <b>JAN 30 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

# CERTIFICATE OF DEATH

1981

County of ...

Birthdate ...

Signature of ...

Married ...

Single ...

White ...

June 25, 1975

U.S.

Residence ...

Principal ...

Elizabeth ...

Joseph Nelson ...

None

Mr. Jennie A. Strawbridge - same item 72-1010



Strawbridge & ...

Center Cemetery

1981/1981

Robert A. ...

Robert A. Humphrey-Bethesda, Maryland

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

945  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 1 Film G279 1-17-61 et  
CERTIFICATE OF DEATH

Reg. Dist. No. 00938

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2813 Hardy Avenue</i>		d. STREET ADDRESS <i>12813. Hardy Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ELWOOD EUGENE STUMP</i>		4. DATE OF DEATH Month <i>January</i> Day <i>12</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July. 5. 1910</i>
9. AGE (In years last birthday) <i>50</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mail Carrier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Post Office</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Samuel Stump</i>		14. MOTHER'S MAIDEN NAME <i>Ida (unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Marguerite E. Stump</i>		Address <i>2813. Hardy ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral anoxia</i> DUE TO (b) <i>Progressive paralysis of respiratory muscles</i> DUE TO (c) <i>Amyotrophic lateral sclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 4</i> , 19 <i>61</i> , to <i>Jan 12</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>Jan 4</i> , 19 <i>61</i> , and that death occurred at <i>8:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eino Magi</i>		DATE SIGNED <i>1/12/61</i>	
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		ADDRESS (Street, city or town, state) <i>918 University Blvd. E. Silver Spring, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1.16.1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>		ADDRESS <i>300.4th.st N E. Wash. D C.</i>	
24a. REC'D BY REGISTRAR <i>Jan 13 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kears</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00939

946

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		d. STREET ADDRESS <u>5301-N.H. AVE N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>MAX</u> Middle <u>SYKES</u> Last <u>SYKES</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERMAN SYKES</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>57705-5463 A</u>	
17. INFORMANT <u>ELLY SYKES</u>		Address <u>APT-109 5301-N.H. AVE. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNDET.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>TUMOR OF URINARY BLADDER, NON-FUNCTIONING LT. KIDNEY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>55</u> , to <u>JAN 23</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>JAN. 22</u> , 19 <u>61</u> , and that death occurred at <u>2:00A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B.P. Lefsky</u> M.D.		ADDRESS (Street, city or town, state) <u>5301-TANGLEWOOD DR. BETHESDA</u>	
PHYSICIAN'S NAME (Type) <u>BENJAMIN P. LAFSKY</u>		DATE SIGNED <u>1/23/61</u> M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/27/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ADAM ISRAEL TEM</u>	22d. LOCATION (City, town, or county) (State) <u>DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bolster Funeral Home</u> ADDRESS <u>4217-9th Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 25 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. I hereby certify that the above is a true and correct copy of the original as shown to me by the person presenting it for registration. I am a duly qualified and licensed physician, and I am not aware of any other person who is qualified to register deaths in this State.

2. I hereby certify that the above is a true and correct copy of the original as shown to me by the person presenting it for registration. I am a duly qualified and licensed physician, and I am not aware of any other person who is qualified to register deaths in this State.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. PLACE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]	
11. SIGNATURE OF REGISTRAR [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF WITNESS [Faint text]		16. SIGNATURE OF DECEASED [Faint text]	
17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF WITNESS [Faint text]		20. SIGNATURE OF DECEASED [Faint text]	
21. SIGNATURE OF WITNESS [Faint text]		22. SIGNATURE OF DECEASED [Faint text]	
23. SIGNATURE OF WITNESS [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF WITNESS [Faint text]		26. SIGNATURE OF DECEASED [Faint text]	
27. SIGNATURE OF WITNESS [Faint text]		28. SIGNATURE OF DECEASED [Faint text]	
29. SIGNATURE OF WITNESS [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF WITNESS [Faint text]		32. SIGNATURE OF DECEASED [Faint text]	
33. SIGNATURE OF WITNESS [Faint text]		34. SIGNATURE OF DECEASED [Faint text]	
35. SIGNATURE OF WITNESS [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
37. SIGNATURE OF WITNESS [Faint text]		38. SIGNATURE OF DECEASED [Faint text]	
39. SIGNATURE OF WITNESS [Faint text]		40. SIGNATURE OF DECEASED [Faint text]	
41. SIGNATURE OF WITNESS [Faint text]		42. SIGNATURE OF DECEASED [Faint text]	
43. SIGNATURE OF WITNESS [Faint text]		44. SIGNATURE OF DECEASED [Faint text]	
45. SIGNATURE OF WITNESS [Faint text]		46. SIGNATURE OF DECEASED [Faint text]	
47. SIGNATURE OF WITNESS [Faint text]		48. SIGNATURE OF DECEASED [Faint text]	
49. SIGNATURE OF WITNESS [Faint text]		50. SIGNATURE OF DECEASED [Faint text]	
51. SIGNATURE OF WITNESS [Faint text]		52. SIGNATURE OF DECEASED [Faint text]	
53. SIGNATURE OF WITNESS [Faint text]		54. SIGNATURE OF DECEASED [Faint text]	
55. SIGNATURE OF WITNESS [Faint text]		56. SIGNATURE OF DECEASED [Faint text]	
57. SIGNATURE OF WITNESS [Faint text]		58. SIGNATURE OF DECEASED [Faint text]	
59. SIGNATURE OF WITNESS [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF WITNESS [Faint text]		62. SIGNATURE OF DECEASED [Faint text]	
63. SIGNATURE OF WITNESS [Faint text]		64. SIGNATURE OF DECEASED [Faint text]	
65. SIGNATURE OF WITNESS [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF WITNESS [Faint text]		68. SIGNATURE OF DECEASED [Faint text]	
69. SIGNATURE OF WITNESS [Faint text]		70. SIGNATURE OF DECEASED [Faint text]	
71. SIGNATURE OF WITNESS [Faint text]		72. SIGNATURE OF DECEASED [Faint text]	
73. SIGNATURE OF WITNESS [Faint text]		74. SIGNATURE OF DECEASED [Faint text]	
75. SIGNATURE OF WITNESS [Faint text]		76. SIGNATURE OF DECEASED [Faint text]	
77. SIGNATURE OF WITNESS [Faint text]		78. SIGNATURE OF DECEASED [Faint text]	
79. SIGNATURE OF WITNESS [Faint text]		80. SIGNATURE OF DECEASED [Faint text]	
81. SIGNATURE OF WITNESS [Faint text]		82. SIGNATURE OF DECEASED [Faint text]	
83. SIGNATURE OF WITNESS [Faint text]		84. SIGNATURE OF DECEASED [Faint text]	
85. SIGNATURE OF WITNESS [Faint text]		86. SIGNATURE OF DECEASED [Faint text]	
87. SIGNATURE OF WITNESS [Faint text]		88. SIGNATURE OF DECEASED [Faint text]	
89. SIGNATURE OF WITNESS [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF WITNESS [Faint text]		92. SIGNATURE OF DECEASED [Faint text]	
93. SIGNATURE OF WITNESS [Faint text]		94. SIGNATURE OF DECEASED [Faint text]	
95. SIGNATURE OF WITNESS [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF WITNESS [Faint text]		98. SIGNATURE OF DECEASED [Faint text]	
99. SIGNATURE OF WITNESS [Faint text]		100. SIGNATURE OF DECEASED [Faint text]	



## CERTIFICATE OF DEATH

Reg. Dist. No.

00940

947

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAVAREST NURSING HOME</u>				d. STREET ADDRESS <u>1013 Osage St</u>			
3. NAME OF DECEASED (Type or print) First <u>PEBBLE</u> Middle <u>E.</u> Last <u>TANNER</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 20 1897</u>	
9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk U.S. Gen Treasury</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Harry Burroughs</u>				14. MOTHER'S MAIDEN NAME <u>Edith Magruder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>8901 Walden Rd Silver Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of uterus with metastasis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>52</u> to <u>28 Jan</u> , 19 <u>61</u> , that I lost saw the deceased alive on <u>27 Jan</u> , 19 <u>61</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Huff</u> M.D.				DATE SIGNED <u>9:06 Collesville Rd, 1/28/61</u>			
PHYSICIAN'S NAME (Type) <u>Silver Spring Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>				ADDRESS <u>4812 Ibawone Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Montgomery Co. Medical Examiner notified and released as Medical Officer was in attendance in ambulance at time of death.

Item 18 Film 279  
1-27-61 ams

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00941

### 948: Birth Cert. et

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>DOA</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Enroute from Station Hosp. Patuxent River, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> d. STREET ADDRESS <b>36 Salamau Court</b> <span style="float: right;">18x2</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Linda</b> Middle <b>Gay</b> Last <b>TATON</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>12</b> Year <b>1961</b>		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>7-16-59</b> <b>9. AGE</b> (In years last birthday) <b>1</b> yrs. <b>IF UNDER 1 YEAR</b> Months <b>Days</b> <b>Hours</b> <b>Min.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland, St. M. Co.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Carl J. TATON</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Betty Marilyn COLE</b>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>(F) Carl J. Taton, same as #2 above</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningitis, acute, bacterial</b> DUE TO <b>340.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>340.0</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Culture positive for H. Influenza</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) <del>XXXXXX</del> attended the deceased from Jan. 12 1961 to Jan. 12 1961, that (I) <del>xxx</del> last saw the deceased alive on Jan. 12 1961, and that death occurred at 11:50AM M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>D. G. ANDERSON, LT, MC, USN</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>Station Hospital, Patuxent River, Md.</b>		<b>22b. DATE SIGNED</b> <b>1-12-61</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1/16/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Mattingly Funeral Home, Leonardtown, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JAN 17 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION



949

## CERTIFICATE OF DEATH

00942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>WARWICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ASHTON</b>				c. LENGTH OF STAY IN 1b <b>3 MONTHS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BELMONT NURSING HOME</b>				d. STREET ADDRESS <b>9606 - 16th ST., EAST OCEAN VIEW</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROSEMARY</b> Middle <b>SUSAN</b> Last <b>UTZ</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>8</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 3, 1885</b>	
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>UNKNOWN ANDREWS</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN RODMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
INFORMANT <b>MRS. HELEN E. JOHNSON, 7414 GEORGIA AVE., N.W.,</b>				Address <b>WASHINGTON, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vary</b> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct 11</b> , 19 <b>60</b> to <b>Jan 8</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1-3</b> , 19 <b>61</b> , and that death occurred at <b>12:50</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED <b>15544 Columbia Rd 1-5-61</b> <b>Burtonsville Md</b>							
ACTUAL SIGNATURE <b>Roy B. Parsons, Jr.</b> M.D. <b>15544 Columbia Rd</b>							
PHYSICIAN'S NAME (Type) <b>ROY B. PARSONS, JR.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>							
22b. DATE THEREOF <b>JAN. 11, 1961</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>FOREST LAWN CEMETERY</b>							
22d. LOCATION (City, town, or county) (State) <b>NORFOLK, WARWICK CO., VA.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.,</b> <b>Raymond A. Ziska</b>							
ADDRESS <b>SILVER SPRING, MD.</b>							
24a. REC'D BY REGISTRAR DATE <b>JAN 11 '61</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1900

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

72

MALE

DECEASED

NEW YORK

ATTEST

DECEASED

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**950** **CERTIFICATE OF DEATH**

60943

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>63 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>St. Petersburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48X-23</b> d. STREET ADDRESS <b>5327 5th Ave. N</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Henry Clifford VAUGHN</b>			4. DATE OF DEATH Month Day Year <b>January 10 1966</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-21-91</b>	9. AGE (In years lost birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Musician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Charles Giles VAUGHN</b>				
14. MOTHER'S MAIDEN NAME <b>Katherine KNOX</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WWI &amp; II</b>				
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>(W) Mrs. Blanche Vaughn, same as #2 above</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic cerebral tumor</b> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchiogenic carcinoma</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 7 mos.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 8 1960</b> to <b>Jan. 10 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 10 1960</b> , and that death occurred at <b>9:55 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>F. M. Highly, Jr.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-11-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>F. M. HIGHLY, JR., LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-16-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			
23d. LOCATION (City, town, or county) <b>Arlington</b>		23e. (State) <b>Virginia</b>		23f. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>		ADDRESS <b>Lee Funeral Home, 4th &amp; Mass. Aves., NW, WashDC</b>		25a. REC'D BY REGISTRAR <b>JAN 13 61</b>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# STATEMENT OF DEATH

1950

1950

1950

Belmont (Hunt)

of days

Set. 1950

U. S. Naval Hospital

3351 3rd Ave. N

Henry

CLIFFORD VAUGHN

January 10

Male

2-21-51

69

Physician

U. S. Navy

Illinois

USA

CLIFFORD VAUGHN

Washington, D.C.

You NW 1/4 11 Rose (W) Mrs. Minnie Vaughn, same as above

1950

1950

1950

Jan. 10

1-11-51

1950

U. S. Naval Hospital, Belmont, Ill.

1-10-51

Washington National

Virginia

1950

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
951  
CERTIFICATE OF DEATH

00944

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>47X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1400 Fairmount St., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Calvin</b> Last <b>VIA</b>			4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>19 61</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>3-7-29</b>		9. AGE (In years last birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months <b>31</b> Days <b>31</b> Hours <b>31</b> Min. <b>31</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>West Virginia</b>			13. FATHER'S NAME <b>James W. VIA</b>		
14. MOTHER'S MAIDEN NAME <b>Mary E. LAFORN</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b> <b>WWII &amp; Korean</b>		
16. SOCIAL SECURITY NO. <b>235 36 9877</b>			17. INFORMANT <b>(W) Mrs. Mary M. Via, same as #2 above</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RHEUMATIC HEART DISEASE INACTIVE ; ( MITRAL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>STENOSIS AND INSUFFICIENCY ; AORTIC INSUFFICIENCY</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b></b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 18</b> 19 <b>61</b> to <b>Jan. 25</b> 19 <b>61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 25</b> 19 <b>61</b> , and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>J. E. McClenathan</b>			22b. DATE SIGNED <b>1-26-61</b>		
22c. PHYSICIAN'S NAME (Type) <b>J. E. MC CLENATHAN, CDR, MC, USN</b>			22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>1-27-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Princeton</b>		23e. (State) <b>West Virginia</b>		23f. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Chevy Chase Funeral Home, 5103 Wisc. Ave. NW, Wash DC</b>			25a. REC'D BY REGISTRAR <b>JAN 30 '61</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			25c. REGISTRAR'S SIGNATURE		

Division of Ordnance

Washington

Department of the Army

U. S. Army Ordnance Corps

1000 Ballpark Rd., N.W.

January 25

Colvin

John

Name

Organization

3-7-32

Headquarters (Bureau)

U. S. Army

Washington

James W. Vile

Mary E. Vile

For: With a return copy to the U. S. Army, which is to be

Jan. 25

Jan. 15

Jan. 5

1-20-32

J. E. McCLINTOCK, CDR, MC, USA, U. S. Army Ordnance Corps, Ft. Belvoir, Ill.

Official Release 1-2-32

Official Release 1-2-32

Official Release 1-2-32

Official Release 1-2-32

Heavy Ordnance Research Group, Army Ordnance Corps, Ft. Belvoir, Ill.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00945											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 31				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,218 COLESVILLE ROAD						d. STREET ADDRESS 10,218 COLESVILLE ROAD 1					
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE ESTHER VIPOND						4. DATE OF DEATH Month Day Year JAN. 31 19 61					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/10/78		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Wisconsin				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Edge						14. MOTHER'S MAIDEN NAME Lucinda Gilbert					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. yes		17. INFORMANT Mr. Louis M. Vipond, 10,218 Colesville Rd. Silver Spring, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Frank J. Broschart M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) FRANK J. BROSCART DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1-31-61 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 22b. DATE THEREOF 2/4/61 22c. NAME OF CEMETERY OR CREMATORY Scales Mound Citizens Cemetery 22d. LOCATION (City, town, or country) (State) Scales Mound, Illinois 23. FUNERAL DIRECTOR RAYNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD. 24a. REC'D BY REGISTRAR DATE FEB 6 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kline											

530

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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953  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
00946

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
c. LENGTH OF STAY IN 1b <i>21 days</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <i>1429 H - Wood Drive</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Bertha Ella Wade</i>		4. DATE OF DEATH Month Day Year <i>Jan. 16 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/5/85</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child's nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>retired</i>	
11. BIRTHPLACE (State or foreign country) <i>France</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Augustus Rolle H</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>566-42-608</i>	
17. INFORMANT <i>Alene R. Wade</i>		Address <i>14224 H - Wood Dr.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral infarction</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cerebral thrombosis</i> DUE TO (c) <i>Cerebral Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i> <i>8 hrs.</i> <i>Indeterminate</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/1/60</i> to <i>1/16/61</i> , that (I) (we) last saw the deceased alive on <i>1/16/61</i> , and that death occurred at <i>6:00</i> M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Stephen N. Jones</i> M.D.		22b. DATE SIGNED <i>1/16/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Stephen N. Jones</i>		22d. ADDRESS <i>Rockville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transit</i>		23b. DATE THEREOF <i>1/17/61</i>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <i>Lenox, Massachusetts</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler</i>		ADDRESS <i>Rockville, Maryland</i>	
25a. REC'D BY REGISTRAR <i>DATE JAN 19 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	

CERTIFICATE OF HEALTH

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Blank form with horizontal lines for text entry.

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FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
954 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
66947														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>									
c. LENGTH OF STAY IN 1b <u>20 ym</u>					d. STREET ADDRESS <u>Md R-121</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md R-121</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Bradley</u> Middle <u>Warfield</u> Last <u></u>					4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1961</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-20-1908</u>		9. AGE (in years last birthday) <u>52</u> yrs.						
						IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>					11. BIRTHPLACE (State or foreign country) <u>Md</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.E</u>				
10b. KIND OF BUSINESS OR INDUSTRY <u></u>														
3. FATHER'S NAME <u>Brady W. Warfield</u>					14. MOTHER'S MAIDEN NAME <u>Georgia King</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>					16. SOCIAL SECURITY NO. <u></u>					17. INFORMANT <u>Viola Warfield Clarksburg</u> Address <u>73 Hammond Dr</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>Found dead on floor of home</u>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Frank J. Broschant</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>1-4-61</u>				
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county) <u></u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Jan. 6 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>			22d. LOCATION (City, town, or country) <u>Laytonsville</u> (State) <u>Md</u>						
23. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville. Md.</u>					24a. REC'D BY REGISTRAR <u></u> DATE <u>JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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John J. Sullivan, M.D., State Medical Examiner

John J. Sullivan, M.D., State Medical Examiner

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

955

00948

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY in 1b <u>7 mos</u>		d. STREET ADDRESS <u>1334 Jexxerson st. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Delia</u> <u>Effie</u> <u>Watkins</u>		f. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Female</u> <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9-17-79</u>		9. AGE (In years last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Parker</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Coghill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 33 1 X DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Cerebral Vascular Accident - 5-20-60</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-20</u> , 19 <u>60</u> to <u>1-12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-12</u> , 19 <u>61</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>1-12-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		22d. ADDRESS <u>7425 Aspen Court Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/15/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Leesburg, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>2901-14th St NW</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		DATE <u>JAN 16 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

956

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

60949

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY <b>Louisville</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Louisville</b> d. STREET ADDRESS <b>648 Eastlawn</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mark</b> Middle <b>Wayne</b> Last <b>Weber</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 24, 1948</b>
9. AGE (In years lost birthday) <b>12</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wayne E. Weber</b>		14. MOTHER'S MAIDEN NAME <b>Vivian Shea</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> DUE TO Widespread Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>199-2</b> (c) <b>1 day</b> <b>9 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 28, 1960</b> to <b>January 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>January 11, 1961</b> , and that death occurred at <b>5:25a</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert B. Scoggins</b> 22c. PHYSICIAN'S NAME (Type) <b>ROBERT B. SCOGGINS, M.D.</b>		22b. DATE SIGNED <b>1-11-61</b> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/12/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Louisville Ky.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>By Song's Funeral Home</b>		25a. REC'D BY REGISTRAR <b>WASH. D.C.</b> 25b. REGISTRAR'S SIGNATURE <b>1300 N. St. N.W.</b>	
25c. DATE <b>JAN 13 '61</b>		25d. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	

CHILDREN

January 11, 1911  
The Clinical Center, National  
Institute of Health, Bethesda, Md.

December 28, 1910 January 11, 1911

No. 10  
Name  
The Clinical Center, National  
Institute of Health, Bethesda, Md., Maryland  
Vivian Shaw

Sex  
Female  
Race  
White  
Date of Birth  
December 21, 1906  
Age  
3 years 11 months  
U.S.A.

Admission  
The Clinical Center, National  
Institute of Health, Bethesda, Md.  
Date of Admission  
January 11, 1911  
Referring Physician  
Louisville

History  
Kentucky  
DEPARTMENT OF HEALTH  
928

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>					
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>33 ROCKVILLE</b>					
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN. &amp; HOSPITAL</b>				d. STREET ADDRESS <b>14308 INDEPENDENCE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
	3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>WESLEY</b> Last <b>WHITNEY</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>17</b> Year <b>19 61</b>					
	5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/17/15</b>		9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Co-owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Wheaton Glass Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
	13. FATHER'S NAME <b>Wesley Whitney</b>				14. MOTHER'S MAIDEN NAME <b>Annie Brown</b>					
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>WW # 2</b>		17. INFORMANT <b>Mrs. Rose M. Whitney, 4308 Independence St. Rockville, Md.</b>			
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>581.1</b> IMMEDIATE CAUSE (a) <b>Blood poisoning duodenal ulcer</b> DUE TO (b) <b>Cirrhosis, Laennec's</b> DUE TO (c) <b>alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>yrs</b> <b>yrs</b>	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>1/10</b> , 19 <b>61</b> , to <b>1/17</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1/17</b> , 19 <b>61</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>16620 Georgia Ave Silver Spring, Md.</b> DATE SIGNED <b>1/17/61</b> ACTUAL SIGNATURE <b>Donald Nelson</b> M.D. PHYSICIAN'S NAME (Type) <b>DONALD NELSON</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>1/21/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Giska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>		

CERTIFICATE OF DEATH

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WILSON

WILSON

WILSON

WILSON

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may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**CERTIFICATE OF DEATH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

958

**CERTIFICATE OF DEATH**

00951

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ABIGAH</b> Middle <b>CALVIN</b> Last <b>WILDER</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>4</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/31/60</b>		9. AGE (In years lost birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>THOMAS CALVIN WILDER</b>				14. MOTHER'S MAIDEN NAME <b>BETTY ANN SUDDUETH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 760.00 DUE TO <b>right left frontal lobe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> 19 <b>60</b> to <b>Jan 4</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Jan 4</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. D. Bonifant</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. D. Bonifant M.D.</b>				22d. ADDRESS <b>Sandy Spring, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 5 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Seal Farm</b>		23d. LOCATION (City, town, or county) (State) <b>Etchison Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Barber</b>				ADDRESS <b>Laytonsville Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 11 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

959

CERTIFICATE OF DEATH

00952

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4822 Morgan Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DURWOOD</b> Middle <b>R.</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>28,</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 8, 1894</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Samuel G. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelm Belcher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 241-12-9996</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of the Liver</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cirrhosis of the Liver</b> DUE TO (c) <b>ARTERY DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> <b>10 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 26 1961</b> to <b>Jan 28 1961</b> , that (I) (we) lost saw the deceased alive on <b>Jan 26 1961</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Leo I. Donovan MD</b>		22b. DATE SIGNED <b>1/29/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEO I DONOVAN MD</b>		22d. ADDRESS <b>8214 WING AVE BETHESDA MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-1-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Foran</b>		25c. DATE <b>FEB 2 '61</b>	

CERTIFICATE OF DEATH

202

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
960														
00953														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>35 Kensington</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10419 <del>Reisterstown</del> Fawcett St.</u>					d. STREET ADDRESS <u>3910 Hampton St.</u>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>John Henry Williams</u>					4. DATE OF DEATH <u>Jan. 30 19 61</u>									
5. SEX <u>male</u>					6. COLOR OR RACE <u>col.</u>									
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Aug. 14, 1890</u>									
9. AGE (In years last birthday) <u>70</u> yrs.					IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Va.</u>									
11. BIRTHPLACE (State or foreign country) <u>Va.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>John Williams</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>I</u>					16. SOCIAL SECURITY NO. <u>Thelma Williams (wife) Item 2</u>									
17. INFORMANT <u>Thelma Williams (wife) Item 2</u>					Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (a), stating the underlying cause last. (c) <u>420.1</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
Address (Street, city, town, or county)										DATE SIGNED <u>1/31/61</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										22b. DATE THEREOF <u>2/4/61</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Elijah.</u>										22d. LOCATION (City, town, or country) (State) <u>Poolesville, Md.</u>				
23. FUNERAL DIRECTOR <u>Snowden Funeral Home, Rockville, Md.</u>										ADDRESS				
24a. REC'D BY REGISTRAR <u>FEB 2 61</u>										24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>				
DATE														

FOR SALE  
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GOVERNMENT

1940

(1)

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

961

06954

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>79 days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>				b. COUNTY <b>McLean</b>																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>								d. STREET ADDRESS <b>6 Bermuda Court</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <b>Louis</b>				Middle <b>Boisseau</b>				Last <b>Sr. WILLIAMS</b>				4. DATE OF DEATH Month <b>January</b>				Day <b>4</b>				Year <b>1961</b>															
5. SEX <b>Male</b>				6. COLOR OR RACE <b>Caucasian</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>7-5-95</b>				9. AGE (In years lost birthday) <b>65</b> yrs.				10. IF UNDER 1 YEAR Months <b>65</b>				11. IF UNDER 24 HRS. Days <b>65</b>				12. IF UNDER 24 HRS. Hours <b>65</b>				13. IF UNDER 24 HRS. Min. <b>65</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Broker</b>								10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>								11. BIRTHPLACE (State or foreign country) <b>Virginia</b>								12. CITIZEN OF WHAT COUNTRY? <b>USA</b>											
13. FATHER'S NAME <b>Green WILLIAMS</b>												14. MOTHER'S MAIDEN NAME <b>Pauline DENNIS</b>																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes 1910 to 1913</b>								16. SOCIAL SECURITY NO. <b>564-14-7675</b>								17. INFORMANT <b>(S) Major L. B. Williams, USAF, same as #2</b>								Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1999.2 Metastatic Carcinoma (Primary Unknown)</b> DUE TO (b) <b>1gr</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <b>1gr</b> DUE TO (c) <b>1gr</b>																INTERVAL BETWEEN ONSET AND DEATH <b>1gr</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis, Hepatic</b>																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>								20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 17, 1960</b> to <b>January 4, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 4, 1961</b> , and that death occurred at <b>10:35 PM</b> , from the causes and on the date stated above.																22a. SIGNATURE <i>John Wood Davis</i> <b>John Wood DAVIS, LT, MC, USN</b>								22b. DATE SIGNED <b>1-5-61</b>											
22c. PHYSICIAN'S NAME (Type) <b>John Wood DAVIS, LT, MC, USN</b>								22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>								22e. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>								23b. DATE THEREOF <b>1-9-61</b>								23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>								23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Kline</i> <b>Arthur L. Kline</b>																25a. REC'D BY REGISTRAR DATE <b>JAN 9 '61</b>								25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i> <b>Arthur L. Kline</b>											

# CERTIFICATE OF DEATH

Name: **WILLIAMS, CLARENCE**  
 Sex: **Male**  
 Date of Birth: **1-2-22**  
 Place of Birth: **USA**  
 Date of Death: **1-2-22**  
 Place of Death: **U. S. Naval Hospital, Bethesda, Md.**  
 Cause of Death: **Brain Tumor**  
 Physician: **Dr. J. H. Williams**  
 Certifying Physician: **Dr. J. H. Williams**  
 Date of Issue: **1-2-22**  
 Place of Issue: **U. S. Naval Hospital, Bethesda, Md.**

I, **Dr. J. H. Williams**, hereby certify that the above is a true and correct statement of the facts of the death of **CLARENCE WILLIAMS**, son of **Mr. and Mrs. J. H. Williams**, of **USA**, who died on **1-2-22** at **U. S. Naval Hospital, Bethesda, Md.**

Signed: **Dr. J. H. Williams**  
 Date: **1-2-22**  
 Place: **U. S. Naval Hospital, Bethesda, Md.**



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

962

00955

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>TEXAS</b> b. COUNTY <b>SHERMAN</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>3 1/2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SHERMAN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>403 Waterford Road</b>				d. STREET ADDRESS <b>P.O. Box 697,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUTHER EDGAR WILLIAMS</b>				4. DATE OF DEATH Month Day Year <b>1 6 19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/11/83</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER (RETIRED)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TIRE RECAPPING</b>		11. BIRTHPLACE (State or foreign country) <b>GRAHAM, VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>GEORGE M. D. WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>SARAH EPPERLY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Willie Myrtle Williams, P.O. Box 697</b> Address <b>Sherman, Texas</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Insufficiency</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 60</b> to <b>Jan 6 19 61</b> , that (I) (we) last saw the deceased alive on <b>Jan 6 19 61</b> , and that death occurred at <b>11:55 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Bernard A. Fitzgerald M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-7-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>BERNARD A. FITZGERALD</b>				22d. ADDRESS <b>217 University Blvd E S.S. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		23b. DATE THEREOF <b>1/11/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WEST HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SHERMAN, TEXAS</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPERY, INC. Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR <b>JAN 11 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

1903

DECEASED

AGE

SEX

WILLIAM

EDWARD

JOHN

1845

1845

1845

1845

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

963

## CERTIFICATE OF DEATH

Reg. Dist. No.

00956

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Burnsville</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burnsville</b> d. STREET ADDRESS <b>Route 4, Box 139</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Garrett</b> Last <b>Wilson</b>		4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 8, 1906</b> 9. AGE (In years last birthday) yrs. <b>54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Turner Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Martha Hensley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>238-26-2433</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral metastases</b> DUE TO (b) <b>Choriocarcinoma</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 5, 1961</b> to <b>January 7, 1961</b> , that I last saw the deceased alive on <b>January 7, 1961</b> , and that death occurred at <b>9:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Michael Z. Lazor</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>MICHAEL Z. LAZOR, M.D.</b>		DATE SIGNED <b>1/7/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-12-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Upper Egypt Township</b>	22d. LOCATION (City, town, or county) (State) <b>Burnsville N.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey, Bethesda, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 10 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00957

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium + Hosp. 1100 Devere Dr</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>15</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lizzie Mae Wilson</b>				4. DATE OF DEATH Month Day Year <b>1 - 26 1961</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-4-94</b>		9. AGE (In years last birthday) <b>66</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abe Crosby</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Pettis</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hilda Champion</b> <b>Margaret Pettis</b> 1100 Devere Dr			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. } DUE TO (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rockville</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Frank J. Broschert</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1-26-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1-30-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cem</b>		22d. LOCATION (City, town, or country) (State) <b>Rockville Md</b>	
23. FUNERAL DIRECTOR <b>Deaf Funeral Home</b>				ADDRESS <b>4812 Blaine Ave NW</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Perma</b>	

MEDICAL CERTIFICATION

M

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2

WASH 106

FOR THE  
RECORD

(1)



1

365

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00958

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>104 North Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>104 North Rockville</u>			
c. LENGTH OF STAY IN 1b <u>5 yrs.</u>				d. STREET ADDRESS <u>104 North Rockville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Maynard Clark Wims</u>				4. DATE OF DEATH <u>Jan. 16, 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 3, 1895</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscaper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Landscaping</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>BENJAMIN WIMS</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Hutchinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Wife: Martha Wims, 104 North Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> DUE TO <u>Metastatic Pulmonary Ca.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostatic Adenocarcinoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>4 mos.</u> <u>2 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 16, 1961</u> to <u>Jan. 16, 1961</u> , that (I) (we) last saw the deceased alive and <u>well</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Clive B. Jackson, M.D.</u>				22b. DATE SIGNED <u>1-16-61</u>		22c. PHYSICIAN'S NAME (Type) <u>202 Martin Ln., Rockville, Md.</u>	
22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley.</u>		23d. LOCATION (City, town, or county) (State) <u>Rocky Hill, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Clive B. Jackson</u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

966

00959

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>(no middle name)</b> Last <b>Witcoff</b>				4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 4, 1896</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundrymat Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel Witcoff</b>				14. MOTHER'S MAIDEN NAME <b>Lieby Witcoff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>231-01-9802</b>		17. INFORMANT <b>The medical Records</b> Address <b>The clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>January 25, 1961</b> to <b>January 29, 1961</b> , that (I) (we) lost saw the deceased alive on <b>January 29, 1961</b> , and that death occurred on <b>12:15 PM</b> the causes and on the date stated above.							
22a. SIGNATURE <b>Richard E. Rieselbach</b> M.D.				22b. DATE SIGNED <b>1/29/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Richard E. Rieselbach M.D.</b>				22d. ADDRESS <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/1/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARL. NAT'L Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>ARL. VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b>				25a. REC'D BY REGISTRAR <b>JAN 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. F...</b>	

CERTIFICATE OF DEATH

300

The Clinical Center, Bethesda, Md., 100

July 1, 1953

White

Female

White

Medical Record

Medical Record

24 hours

Respiration Normal

Arterial Blood Pressure Normal

January 20, 1954

January 20, 1954

The Clinical Center, Bethesda, Md., 100

The Clinical Center, Bethesda, Md., 100

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

967

CERTIFICATE OF DEATH

Items 1, 11 Film 6279 1-12-61 et

00960

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>5 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mrs. Green's Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>—</i> Last <i>Young</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>2</i> Year <i>1961</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1875</i>
9. AGE (In years lost birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-keeping</i>		12. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
13. FATHER'S NAME <i>Wesley Foreman</i>		14. MOTHER'S MAIDEN NAME <i>Winnie Warren</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Hattie Ann Sims, R3, Gaithersburg, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>158.9</i> DUE TO <i>Cancer of intestine</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Multiple sclerosis,</i> (c) <i>2 years</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>years</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1950</i> to <i>Jan - 2 - 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec - 25 - 1960</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>William C. Miller</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER, MD</i>		22d. ADDRESS <i>78 Brook Ave., Gaithersburg, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/6/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rocky Hill Cem.</i>		23d. LOCATION (City, town, or County) (State) <i>Clarkburg, Ind.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Mawden</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 9 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

MEDICAL CERTIFICATION



1920

John F. Miller

John F. Miller

1920

John F. Miller

John F. Miller

1920

John F. Miller

John F. Miller

John F. Miller

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John F. Miller

1920

1920

John F. Miller

John F. Miller

John F. Miller



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

968

CERTIFICATE OF DEATH

66961

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN lb <i>11 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> d. STREET ADDRESS <i>4502 - 13th. Street, N. W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY</i> First <i>CLOTILDA</i> Middle <i>ZANE</i> Last <i>ZANE</i>		4. DATE OF DEATH 1 Month <i>1</i> Day <i>9</i> Year <i>19 61</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-6-86</i>	
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>4</i> Hours <i>13</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>PA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>James P. McDonald</i>		14. MOTHER'S MAIDEN NAME <i>Ellen C. Close</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Pt. in Charge - Washington Sanitarium &amp; Hospital</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>—</i> (a), stating the underlying cause last. DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>13 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Previous Thrombosis Left Hemiplegia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-29</i> , 19 <i>60</i> , to <i>1-9</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>1-8</i> , 19 <i>61</i> , and that death occurred at <i>9:45</i> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard L. Clapp MD</i>		22b. DATE SIGNED <i>1-9-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Richard L. Clapp, MD</i>		22d. ADDRESS <i>7600 CARROLL Ave Takoma Park, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>1/12/1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Dennis Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Havertown, Pennsylvania</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		25. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
25a. REC'D BY REGISTRAR <i>JAN 11 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

(M)

(I)

THE J. L. Hines Co. Washington D.C.  
2701 14th St. N.W.  
Lombard - 1412 14th St. N.W. Washington D.C.  
BENJAMIN H. HINES, President

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b>  <div style="display: flex; justify-content: space-between;"> <div> <p><i>BuChant</i> 14-39</p> <p><b>969</b></p> </div> <div> <p><b>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</b></p> </div> <div> <p><b>02171</b></p> </div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>2 HRS.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>36</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>						d. STREET ADDRESS <u>11714 HATCHER PLACE 1</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>BABY</u> First <u>GIRL</u> Middle <u>ZAZANIS</u> Last <u>ZAZANIS</u>						<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>29</u> Year <u>1961</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1-29-61</u>		<b>9. AGE</b> (In years lost birthday) yrs. <u>2</u> <u>15</u>		<b>IF UNDER 1 YEAR</b> Months <u>2</u> Days <u>15</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>—</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>JAMES MICHAEL ZAZANIS</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY EVELYN PITTS</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> Address <u>MOTHER</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>761.5</u> IMMEDIATE CAUSE (a) <u>Premature rupt Membranes</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> (b) <u>Premature labor at 25 weeks</u> lying cause lost. (c) <u>—</u>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>12</u> to <u>19</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>Albert S Bright</u>						<b>22b. DATE SIGNED</b> <u>1/29/61</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ALBERT S BRIGHT</u>						<b>22d. ADDRESS</b> <u>8218 WISCONSIN AVE BETHESDA</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>CREMATION</u>				<b>23b. DATE THEREOF</b> <u>JAN. 31-'61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SUBURBAN HOSPITAL</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>OLD GEORGETOWN RD, BETHESDA, MD.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>SUBURBAN HOSPITAL FOLD GEORGETOWN RD, A. CARTER, ADMINISTRATOR, BETHESDA, M.D.</u>						<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>			

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STATE OF TEXAS

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TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

970

## CERTIFICATE OF DEATH

Item 14 4310279 1-16-61 et

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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Manor Sanatorium</i>		d. STREET ADDRESS <i>5515 Hawthorne Pl., N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Malcolm Joseph Zimmerman</i>		4. DATE OF DEATH Month Day Year <i>1 7 1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 17, 1884</i>
9. AGE (In years lost birthday) <i>76 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michael P. Zimmerman</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Myers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>A</i>	
17. INFORMANT <i>Mr. Clarence Zimmerman</i>		Address <i>5515 Hawthorne Pl. Wash. 16, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 7, 1961</i> to <i>June 7, 1961</i> , that (I) (we) lost saw the deceased alive on <i>June 7, 1961</i> , and that death occurred at <i>348 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Andrew E. Rudnith</i>		22b. DATE SIGNED <i>11/7/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>ANDREW E. RUDNITH</i>		22d. ADDRESS <i>1120 MacArthur Blvd. Wt.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/10/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Shanstown</i>		23d. LOCATION (City, town, or county) (State) <i>Clear Spring, Md. D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Fred W. Kraies</i>		ADDRESS <i>Hagerstown, Md</i>	
25a. REC'D BY REGISTRAR <i>JAN 11 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Andrew E. Rudnith</i>	

1924

Oct. 15 1924

Day Register

Michael D. Zimmerman

Michael D. Zimmerman

Michael D. Zimmerman

Michael D. Zimmerman

Michael D. Zimmerman

Michael D. Zimmerman